Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2012 09001

	1- For State Registrar		Certificate	of Death		Reg	ı. No.	
Physician/		الطالعة (Aiddle,Last)				2. Date of Death		3. Time of Death
Medical Examine	LAVINA RITA	HUGLER				Month March 10, 2	Day Year 2012	1235 hrs
)		itution, give street and number))	4b. City, Town,	or Location of Dea	ith	4c. County of Dea	
	7403 16th Avenue			Hyattsville			Prince Georg	je's
Funeral	5. Social Security Number	6. Sex 7. Ag	e (In yrs. last birthda	y) If Under 1 Ye	ear If Under 24H	lrs. 8. Date of Birth	(MM/DD/YYYY) 9. B	
Director	217 70 9020	1 M 2 X F	0.1	Yrs. Months Da	ys Hours M	in. 02/26/	Fore 1021	ENNSYLVANIA
	217-70-8030 Usual Residence of Decede		91			02/20/	1921 P	ENNSILVANIA
a oy	10a. State 10b. Co.		10c. City, Town or L	ocation				10d. Inside City Limits
		war aronaria						1 Yes 2 XNo
ryland a-f show t soce.	MD PRI	NCE GEORGE'S	HYATTSVI	10f. Zip Code		100	g. Citizen of What Co	untry?
the Maryland or 28a-f sh tiffed at 0000							,	
th the last of the	7403 16TH AV			20781			NITED STA	
MD 21215-0036 2 should be filed within 72 hours after death with the Maryland hand Mental Hygiene. 27 is marked other than "natural", or items 23a or 23a-f sho matic evect, the Medical Law her must be notified at noce. To Be Completed by Funeral Director	11. Marital Status 1 Never Married 2	12. Was Decedent Armed Forces?		 Was Decedent of H If Yes, specify Cub 			14. Race - Ame White, etc.	erican Indian, Black,
or it		1 Yes 2	X No	 .				
af Fig. 9	45 December 1 -	Divorced If Yes, Give Yeer or Dates:	140- 0-		lo specify:	c		ITE
5-0036 ed within 72 hours aft tygiene. other than "natural" he Medical Examine Completed by	Elementary/Secondary (0	(Specify only highest grade con -12) College (1-4 or	duri	edent's Usual Occup ng most of working li			16b. Kind of Busines:	sindustry
5-0036 led within 72 he Hygiene. other than "na the Medical Ea	Elementary/secondary (C	-12) College (1-4 of						
5-0036 led within 7 Hygiene. other than the Medica	12	445 4 545	HOM	EMAKER	L 40 Mathada Na	es a Ciack Maidalla Ma	OWN HOME	
Filed Hyge		•			18.Mothers Nar	me (First, Middle, Ma	aiden Surname)	
2121 2121 wild be fi Mental J marked ic event,	MORRIS SAMUE		Tank M	allia a Addas as 101		IVIAN JEN		. 7: 0 11
ID 21215-003 1: should be filed withit and Mental Hygiene. 17 is marked other of matic evect, the Met To Be Com!	1			,			er, City or Town, Sta	
ore, MD 2121. s I and 2 should be fill of Health and Montal B If item 27 is marked nor traumatic evect, To Be	EDWARD HUGLE	CR / SON		S. WATER			WN. MARYL	
	20a. Method of Disposition	nation 3 Removal from St		or other place)	emetery,	Date	20c. Location - City of	or rown, state
MOFG Pages 1 lent of H	4 Donation 5 Oth	_		EAKE CREM	АТТОИ 03	/12/2012	STEVENSVI	LLE, MARYLAN
Baltimore, permit. Pages la Department of He Important: If ite injury or other tr	21. Signature of Funeral Se			22 Name and Addre	ss of Facility	TN C MELIN	AM FINEDA	L HOME, P.A.
E E E E	Hary Ka	· Fellows		130 SPEER	ROAD CH	ESTERTOWN	MARYLAN	D 21620
/ Physician	23a. Part I. Enter the diseas	e, or complications that caused						Approximate Interval Between Onset and
/Medical	Immediate Cause (Final dis	thus a standard A	therosclerotic C	ardiovascular D	isease			Death
Examiner	or condition resulting in dea							
	Sequentially list conditions,	b						
180			sequence of):					
ted Insit	(Disease or injury that initia	ted C.	editence of).					
m ist	events resulting in death) I	d.	equence or).					
760, icate be executed physician and the burial - transit	UNPENDED	AMENDED						
760, ficate be g physicia the buris	IF FEMALE:						Tood Date of delive	
876 ificate ig phy is the	LOD. Was decoder pregnan	t in the 23c. If yes, outcome 1 Live birth	me of pregnancy	Fetal death 3	Ectopic preg	nancy	23d. Date of delive Month	Day Year
ox 68 ath certif attending or use as	past 12 months?		t time of death 5	Other (Specify)				
). Box 68 the death certiful by the attending ched for use as	1 Yes 2 V No 9	Unknown 9 Unknown	_					
O at the tacket tacket	Part il. Other significant co	onditions contributing to deat	th but not resulting in	the underlying cause	given in Part I.	23e. Did tob	acco use contribute	to the cause of death?
Division of Vital Records, P.O. Box 68 tal or Atteoding Physiciae: The law requires that the death certif is after death. **In Director: After this certificate has been signed by the attending led in by the funeral director, page 2 should be detached for use a partification: To Be Commisted by Physician						1 Yes	2 No 3 Pr	obably 4 🗹 Unknown
Records, The law requires ficate has been signant a page 2 should be						24a. Was ar		autopsy findings available
COT law has t						autops	ned? death?	
Red The Page Co.						1 ✓ Yes 2	No 1	Yes 2 No
E certi	25. Was case referred to me examiner?	Hospital:			ce of Death (Che			
Physical directions	1 ✓ Yes 2 No	i iiipalie	ent 2 ER/Outpa				Residence 6 🗸 Oth	ner: Scene
Afte funer	27. Manner of Death 1 ✓ Natural 5	28a. Date of Inju (Month, Day,)	Year) 285. Time		njury at Work?	28d. Describe no	ow injury occurred	
tteod death tor: / the	2 Accident	Pending Investigation		1_	Yes 2 No			
or A Direction by Hifter	3 Suicide 6	Could not be	njury - At home, farm,	street, factory, office	e building, etc.	28f. Location (St or Town, Sta		Rural Route Number, City
Division o spital or Atteoding tours after death. oeral Director: Aft filled in by the fune	4 Homicide	determined (Specify)				J	,	
Hos 24 h		ng Physician: To the best of m					The second second	
Division of Vital Records, P.O. Box 68 To the Hospital or Attending Physiciao: The law requires that the death certif within 24 hours after death. To the Fuoeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as completely filled in by the funeral director, page 2 should be detached for use as a facility of the funeral director.	one) 2 Medica	i Examiner: On the basis of exa and manner stated:		stigation, in my opini	on, death occurre	d at the time, date a	nd place, and due to	the cause(s)
2	29b. Signature and title of o			29c. Lice	nse number		29d. Date signed (A	fonth, Day, Year)
3		11/		0.0	C.M.E.		March 11, 2012	2
	30. Name and address of p	erson who completed cause of	death (Item 23a)					
.45	, .	Deputy Chief Medical E		W. Baltimore S	reet, Baltimo	re, MD 21223		
Stat	* ;		ar's Signature	hold				
Renistra		KASZUIZ ZA	with it.	14				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 3 Year Hudgins Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** County of Death Medical trince MASH/ AS Center 10 Social Security Number 8. Date of Birth (Month, Day, Yo 7. Age (In yrs. last birthday) If Under 1 Year 9. Birthplace (State or Foreign Funeral 1 **X** M 2 □ F Days 579-80-3619 2 Yrs. **Director** Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits **Funeral Director** 28a-f Maryland 1 X Yes 2 No harles 0 10e. Street and Number 10g. Citizen of What Country? USA 20616 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🏿 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. ō Completed by 1 X Never Married 2 Married 1 ☐ Yes If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: "natural", 3 Widowed 4 Divorced Specify: Year or Dates Black 27 is marked other than "natural traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Mental Hygiene. 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ erett Marie Tolson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 i 2644 Basingstoke Tracy Henderson Hance MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or ot once. Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) -13-12 Andove 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 141) 23a. Pal. 1. Enter the disease, or complications that — used the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Ventricular Immediate Cause (Final -ibrillation Physician/ disease or condition Medical resulting in death) Due to (or as a consequence Examiner 40 Cardia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examine Due to (or as a consequence of attending physician and for use as the burial-tran Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: ed by the attendin detached for use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Pregnant at time of death Day Year 1 Yes 2 9 Unknown 2 No Linknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by pertension tor: After this certificate has been significate the funeral director, page 2 should be 1 Tyes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No After this certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital 2 No Other: မ 1 🗌 Yes 1 ☐ Inpatient 2 ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 1 Natural 28d. Describe how injury occurred Hospital or Attending 24 hours after death. 5 Pending work? 2 🗌 No Accident Investigation Director: Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital of within 24 hours a To the Funeral D Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier The basis of the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier D46741 2012 MO of person who completed cause of death (Item 23a) (Type, Print) MD Dachdeva Livingston Year 8 32. Registrar's Signature State Registrar

Registrar

DHMH 17 Rev 06-2011

State

110 BAUGHMAN'S Lone Sate 140

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

200 -

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day} 2012 Physician/ March 5 10:34 P M Norman Lee Kerns Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's Southern Maryland Hospital Center Clinton Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** Hours Min. (Month, Day, Year) 212-32-7202
Usual Residence of Decedent Director 1 🕅 M 2 🗆 F 76 9/12/1935 Maryland ms 23a or 28a-f show must be notified at 10a. State 10d. Inside City Limits 10b. County 10c. City. Town or Location Director 1 Yes 2 No Marvland | Anne Arundel Davidsonville 10e. Street and Numbe 10g. Citizen of What Country? 21035 USA 882 A Governor Bridge Rd. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. and Mental Hygiene.
is marked other than "natural", or item rmed Forces?
X Yes 2 \ No Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates 1954-58 3 Widowed 4 X Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) within 7 College (1-4 or 5+) Elementary/Secondary (0-12) Roofing Company 12th Roofer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Gertrude H. Scroggins George F. Kerns traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 is r any injury or other traumonce. 10505 Cedarville Rd., Lot 6-4, Brandywine, MD 20613 Anna M. Riley/ Friend altimore, 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place, 1 K Burial 2 Cremation 3 Removal from State MD Veterans Cemetery 3/8/12 4 ☐ Donation 5 ☐ Other (Specify) Crownsville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Acute Atheroscierone Cardioviscular Disease Ph_sician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Hypertencian. Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Due to (or as a consequence of): Examir burial-transi Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): inding physician a use as the burial Physician/Medical that the death certificate be P.O. Box 68760 IE EEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) Pregnant at time of death signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Acciden Cereprovacemen Division of Vital Records, 1 Yes 2 No 3 Probably 4 nknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 \(\sum \) Yes \(\sum \) No Fibrilahm-24a. Was an autopsy performed Yes 2 this certificate has ral director, page 2 Yes To the Hospital or Attending Physician: within 24 hours affer death.

To the Funeral Director After this certified completely filled in by the funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) Hospital 1 Yes 2 No 1 Inpatient 2 A/Outpatient 3 IDOA မြ 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of Certificate: 28d. Describe how injury occurred iniury 1 Natural 2 Accident 5 Pending Investigation 6 ☐ Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one)

State

Registrar

29b. Signature and title of certifie

Hospital

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CONTA

MAR 07 2012

DHMH 17 Rev 06-2011

7503 SUWE 143

32. Radistrar's Signature

29c. License number

Road

D50669

ANILEMMHATON MD.

29d. Date signed (Month, Day, Year)

03106

2012

southern mampany

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 09005 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 6^{Day} Physician/ MARCH 2012 RITA WILNETTE KANADY 6:00 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 3908 MAIN STREET GRASONVILLE QUEEN ANNE'S . Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 9. Birthplace (State or Foreign **Funeral** 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Hours 217-56-3394 Director 1 □ M 2 🕱 F 61 08/14/1950 MARYLAND 28a-f show at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director notified OUEEN ANNE'S MD GRASONVILLE 1 Yes 2 X No 10e. Street and Number 10f. Zip Code ö 10g. Citizen of What Country? must be 23a Funeral 3908 MAIN STREET 21638 UNITED STATES 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 K No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. ò ģ 1 Never Married 2 X Married Yes Yes, Giv Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural", WHITE Completed 3 Widowed 4 Divorced Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) nould be filed within 72 and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) the HOMEMAKER OWN HOME 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental His marked of ပ JOHN ASBURY BEASLEY CAROLYN MULLER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) and 2 sr f Health r / item 27 FRANK KANADY / SON 719 LOVE POINT ROAD, STEVENSVILLE, MD 21666 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of Important: If it any injury or o CHESAPEARE CREMATION \square Burial 2 $\overset{f X}{f X}$ Cremation 3 \square Removal from State 03/07/2012 4 ☐ Donation 5 ☐ Other (Specify) STEVENSVILLE, MD Signature of Funeral Service Licer 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A.
106 SHAMROCK ROAD, CHESTER, MD 21619 23a. Part 1. Enter the disease, or complications that sused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ orehow disease or condition resulting in death) Medical **Examiner** Sequentially list conditions if any, leading to immediate Due to (or as a consequence of): Exami Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): physician Completed by Physician/Medical Box 68760 the as 1 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Live Birth 2 - Fetal death Month Pregnant at time of death Day the a 9 Unknown P.0. signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has autopsy perform Yes 2 Olo Division of Vital completely filled in by the funeral director, Be (25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 **P**No 2 1 Tes Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? Certificate: 28b. Time of 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After Hospital or Attending 1 PNatural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and person who completed cause of death (Item 23a) Type, Print)

Registrar
DHMH 17 Rev 06-2011

State

Registrar's Signa

2012

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	_	State Registrar 1. Decedent's Name (First, Middle, L	cott		Certif	ficate of De	eath	1	Reg. No. 2) 2	,09006
Physicia			DWARD KIMBA	ALL JR.				2. Date of Dea Month MARCH	_	0 1 2 ear	3. Time of Death 01:20PMM
Medic Examin		4a. Facility Name (if not institution, g	ive street and number)		4	b. City, Town, or L				y of Death	
Funeral Director		5. Social Security Number 214-20-7192	Sex 7. Ac	ge (In yrs. last birth	//		Hours Min.	8. Date of Birth MAY 18			nplace (State or Foreign otry) LAND
show at	'n	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Locati	ion					10d. Inside City Limits
Maryla 28a-f s otified	Director	MARYLAND CECI	IL	ELK	TON						1 XX Yes 2 □ No
3a or		10e. Street and Number				10f. Zip Code	0.1		10g. Citizen of		-
ems 2	Funeral	16 4TH AVENUE 11. Marital Status	12. Was Decedent		13. Was	219 Decedent of Hisp	anic Origin? (Sp	ecify Yes or No-	UNITI		can Indian,
ars arter death with the Maryland ural", or items 23a or 28a-f show I Examiner must be notified at	þ	1 Never Married 2 Married 3 X Widowed 4 Divorced	If Yes Give		If Ye	es, specify Cuban, Yes 2 K No	Mexican, Puerto	Rican, etc.)		ck, White,	
z should be lied within 7z hours are 27 is marked other than "natural"; traumatic event, the Medical Exar	Completed	15. Decedent's (Specify only highest Elementary/Seconday (0-12)			(Give kind life. DO N	t's Usual Occupati d of work done dur IOT use retired)	ing most of work		16b. Kind of EUNITED	STAT	
tal Hygie d other event, tl	Be	12 17. Father's Name (First, Middle, Las	t)	L	COMP	LIANCE O		ne (First, Middle, I	GOVERNI Maiden Surnarr		
d Ment marke matic	욘	JAMES EDWARD KIN 19a. Informant's Name/Relationship		T			DORIS	•			
of Health and I item 27 is other trau		M. REBECCA MURRA			_	NS ROAD,				State, Zip 219	'
rage randoment of H		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Society)		·	y, cremate	on (Name of ory or other place) CREMATOR	y MARGI	Date H 7,	20c. Location		-
Definit. Fage 1 of Department of Important: If ite any injury or ot once.		21. Signature of June a Service in	/		22. N	ame and Address	of Facility C	ROUCH FU	NERAL I	HOME,	
		2 Part 1. Enter the disease, or co shock, or heart failure. List only									Approximate Interval Between
nysician/ Medical	Ŋ	Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as	a construence o	1 tu	1 asu	iv	- 2			Onset and Death
Examiner	er	Sequentially list conditions, if any, leading to immediate	b. Due to (or as	a consequence o	Imi	hive pu	1 mymy	Alk	450		
and -transit	xaminer	cause. Enter Underlying Cause (Disease or linjury that initiated events	c	mento							
hysician a		resulting in death) Last	d	a consequence o	"hal	Wh'n					
ending p	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	of pregnancy 2 Fetal death	3 □ 5	ctonic pregnancy			23d. D	ate of deliv	/ery
y the att	hysici	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		at time of death		ther (specify)			M	onth	Day Year
signed b	ğ	Part II. Other significant conditions	contributing to death	but not resulting in	the unde	erlying cause giver	in Part I.				the cause of death?
within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician completed filled in by the funeral director, page 2 should be detached for use as the burial	Completed							24a. Was a autop: perfor 1	ev/	prior to co death?	opsy findings available ompletion of cause of
ertificat ctor, pa	Be C	25. Was case referred to medical exampler?				26. Place	e of Death (Chec		2 /ZTN0	1 🗆 Yes	2/11/0
this ce al dire	၉	27. Manper of Death	Hospital: 1 Inpat	ient 2 ER/Out	<u> </u>		4 Nursing H	ome 5 Reside			y)
leath. Ior: After the funer	Certificate	Natural 5 Pending 2 Accident Investigat 3 Suicide 6 Could no	ion	ay, Year) in	ijury		t es 2 🗆 No	28d. Describe ho	w injury occur	red	
urs after (ral Direc lled in by		4 Homicide determine	28e. Place of Inj	ury - At home, far c. (Specify)	m, street,	tactory, office		28f. Location (St City or Town		per or Rura	d Route Number,
the Fune	Medical	(Check 2 Medical Exa	hysician: To the best or miner: On the basis of the traction of the	examination and/or	investiga	tion, in my opinion,	death occurred a	at the time, date an	d place, and du	ue to the ca	ause(s) and manner stated.
To 1		29b. Signature and title of certifier	Μþ.			29c. License n	wind ber / L	/ 2	9d. Date signe	b 1	Day, Year)

DHMH 17 Rev 7/2009

State Registrar

5+1VA

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MM

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

W

31. Date file (Nonth, Pay Year)

8 201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1	For State Of IVI	aryland / Depa <i>Cer</i>	tificate of D			eg. No. 🤈 🕦	12 0900
	Physicia	_	Decedent's Name (First, Middle, Last) JAMES GREGORY LUDDEN				2. Date of Death Month	Day	Year 6.24 AM
	Medic Examin	al	4a. Facility Name (if not institution, give street and number)		4b. City, Town, or	Location of Death	63-	4c. County of	of Death
		ш	Coastal Hospice at the 5. Social Security Number 6. Sex 7. Ag	e (In yrs. last birthday)	Sculis	bury If Under 24 Hrs.	8. Date of Birth		9. Birthplace (State or Foreign
	Funeral Director		397-24-8030 1 № 2 □ F	81 Yrs.	Months Days	Hours Min.	(Month, Day, 8-14-19	Year)	VISCONSIN
	and show lat	ō	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	cation				10d. Inside City Limits
	Maryk 28a-f notified	Director	MARYLAND WORCESTER	OCEAN PIN	ES 10f. Zip Code			l 0g. Citizen of W	1 Yes 2X No
	with the 23a or ust be r	Funeral L	10e. Street and Number 4B BLUE BILL COURT		21811			US	nac occura y r
5-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Mavland Department of Heatht and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	11. Marital Status 1 Never Married 2 M Married 3 Widowed 4 Divorced 12. Was Decedent I Armed Forces? 1 X Yes 2 I If Yes, Give Year or Dates.	Ever in U.S. 13. 1 No 51-56	Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 🋣 No	ispanic Origin? (Spe n, Mexican, Puerto Specify:	cify Yes or No- Rican, etc.)		e - American Indian, k, White, etc. WHITE
15-0	72 hour In "natu Medical	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give	O NOT use retired)	ation during most of worki	- 1	16b. Kind of Bu	
	d within lygiene. ther than	Be Co	Elementary/Secondary (0-12) College (1-4 or :	SALES	AGENT	18. Mother's Name		LIFE IN	
land	should be filed within 72 in and Mental Hygiene. 7 is marked other than "raumatic event, the Med	10 B	17. Father's Name (First, Middle, Last) CLEMENT LUDDEN			MARIE MO		margeri durrame)	
	nd 2 should ealth and N m 27 is ma ner trauma		19a. Informant's Name/Relationship (Type, Print) PATRICIA B. LUDDEN/SPOUSE	4B BL	UE BILL C	CT, OCEAN	PINES,	MD. 218	11
altimore,	Page 1 al ment of H tant: If itel tury or oth		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Dopation 5 ☐ Other (Specify)	MELSON'S	cr other place CREMATOR	3-7-2		FRANKFO	City or Town, State RD, DELAWARE
Balt	permit. Page Department o Important: If any injury or once.		21. Signature Furrial State Discovere	M 4	ELSON FUN 3 THATCHE	TERAL SER	VICES, LT ANKFORD,	DELAWA	RE. 19945
_	h, i ian/ Medical	3) (23a. Part 1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each lin Immediate Cause (Fina disease or condition resulting in death)	N	er the mode of dyin	g, such as cardiac	or respiratory arre	est,	Approximate Interval Between Onset and Death
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	ed nsit	miner	Sequentially list conditions, if any, leading to immediate Due to (or as cause. Enter Underlying Cause (Disease or injury	a consequence of):					
	ate be executed physician and the burial-transit	edical Examiner	that initiated events C.	a consequence of):					
200	cate be physical s the bu		d						
Box 68	requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-trans!	by Physician/M		2 Fetal death 3 at time of death 5	☐ Ectopic pregnand ☐ Other (specify)	cy		23d. Dat Moi	te of delivery nth Day Year
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Records,	he law requate has been bage 2 shou	Completed					24a. Was a autop perfor 1 Yes	sy F	Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No
ital	Physician: T this certifica ral director, p	Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital:		Oth	lace of Death (Chec	, ,		er (Specify) HOSPICE
of Vital	ding Physician: The law h. After this certificate has funeral director, page 2	te: To	27. Manner of Death 28a. Date of inju			ry at	ome 5 Resid 28d. Describe ho		
Division	Attending er death. rector: After by the fune	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of In	jury - At home, farm, st	M 1	Yes 2 No	28f. Location (S City or Town		er or Rural Route Number,
Οį	To the Hospital or Attend within 24 hours after death To the Funeral Director: / completely filled in by the	Medical C	29a. Certifier 1 Certifying Physician: To the best of Chapter 2 Medical Examiner: On the basis of	of my knowledge, death	stigation, in my opini	ion, death occurred a	at the time. date a	nd place, and due	e to the cause(s) and manner stat
	Fo the Parithin 2 Fo the Foomplet	ğ	only one) 3 Certifying Nurse Practitioner: To t	he best of my knowledg	e, death occurred at 29c. Licens	the time, date and p	lace, and due to the	ne cause(s) and n	d (Month, Day, Year)
)		Mellen	n	D 6	0515		3/5/1	1
DA	(6+1		M.THIMMARATAPPA	death (Item 23a) (Type,	Print) FRN 5H	MEDA,	SALIST	BURY	MD 21804
	Sta Registi		31. Date filed (Month, Day, Year) 32. Regist MAR 0 8 2012	trar's Signature	barker				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year EVELYN REBECCA LOCKARD MARCH 201 03:25 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death ELKTON CARE AND REHAB CECIL ELKTON Social Security Number 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Day, Year) Country)
26,1922 TENNESSEE 1 □ M 2 🗓 F Months Hours Director 239-26-2819 89 MARCH Usual Residence of Decedent 28a-f show 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland must be notified at Director 1 Yes 2 ☐ No MARYLAND CECIL NORTH EAST 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 102 PENNSYLVANIA AVENUE 21901 UNITED STATES 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Examiner Black, White, etc. ŏ 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Specify: WHITE "natural" 3 X Widowed 4 Divorced traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) MEDICAL SUPPLIES and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) QUALITY CONTROL SPECIALIST MANUFACTURER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ WILLIAM B. TRIBBLE LOLA MILLER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a SHARON A. VECCHIO / DAUGHTER 2300 MANOR CIRCLE, HAVRE DE GRACE, MARYLAND 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State MARCH 10 Page 1 Department of Important: If it any injury or o 1 XBurial 2 Cremation 3 Removal from State NORTH EAST, MARYLAND 4 Donation 5 Other (Specify) CROUCH FUNERAL HOME, P.A. 21. Signat eral Ser ice Licensee 22. Name and Address of Facility 127 SOUTH MAIN STREET, NORTH EAST, MARYLAND21901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Ęπysiciam disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence or). as the burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical requires that the death certificate be Box 68760 IF FEMALE nse outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ Live Birth 2 - Fetal death in the past 12 months?
1 Yes 2 No Pregnant at time of death Month Year Day be detached 9 Division of Vital Records, P.O. Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? 1 ☐ Yes 2 ☐ No or Attending Physician; 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of injury (Month, Day, Year) 27. Manger of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After Natural 5 Pending 1 Tes 2 🗆 No Investigation Accident filled in by the 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certification 29c. License number 29d. Date signed (Month, Day, Year) MD SHAHNAWAZ KHAN 12_ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2533 AUGUSTINE SVITEA, CHESAPEAKE CITY, MD 21915 HERMAN 31. Date filed (Month, Day, State

DHMH 17 Rev 7/2009

Registrar

2012

Pleased Type or Print in Black Indelible link # Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2012 03 Month Physician/ 03 6:30 P Joycelee Bussard Leatherman Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Middletown 7822 Myersville Rd. If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) MD Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Hours 1/30/1949 Director 63 214-54-0592 1 M 2 F Usual Residence of Decedent 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at Director 1 ☐ Yes 2 🎦 No Myersville MD Frederick 10708 Harp Hill Rd. 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 10708 Harp Hill Rd. 21773 USA Page 1 and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11 Marital Status Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. 1 Never Married 2 X Married þ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify White If Yes, Give Specify: 3 Widowed 4 Divorced Completed Year or Dates. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) public schools custodian Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Anna Louise Delauter Harry L. Bussard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number City or Town, State, Zip Code) 10708 Harp Hill Rd., Myersville, MD 21/73 Harold E. Leatherman (Husband) 20b. Place of Disposition (Name of Grooms to Trental by or Ghendrace) 0 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 3/7/2012 Myersville, MD Brethren Cemetery ure of Furniral 22. Name and Address of Facility
Donald B. Thompson Funeral Home
31 E. Main St., Middletown, MD 21769 Sign ons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Part 1. Enter the disease, or complica shock, or heart failure. List only one complications of the complete shock, or heart failure. Immediate Cause (Final MATAGTATE Merhel Physician/ (011 disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): sician and burial-trans Due to (or as a consequence of) resulting in death) Last ed by the attending physician detached for use as the buria Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be e. 24 hours after death.
Funeral Director: After this certificate has been signed by the attending physicia Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Dav Year 5 Other (specify) 9 Unknown ate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2 filled in by the funeral director, 26. Place of Death (Check only one) Be 25. Was case referred to medical Sister's Other: 4 \(\sum \) Nursing Home \(\frac{\frac{1}{2} \sum \) Hesidence \(6 \sum \) Other (Specify) 1 ☐ Yes 2 ☑ No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA House 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 🔲 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 03-05-2012 D0067691 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5. Frederick, MD 21761 120 501 Goldstein 6. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ LEWIS THAYER JOHN MARCH 2012 8:45P Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 10462 WILLETTS CROSSING ROAD WHITE PLAINS CHARLES 9. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthdav) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth 6. Sex **Funeral** Days Hours Min DEC. 1, 1938 1**x** x 2 □ F Yrs. Director 009-28-1149 Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director 1 Yes 2 XXI WHITE PLAINS MD CHARLES 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 10462 WILLETTS CROSING ROAD WHITE PLAINS U. S. A. · death v 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. , Or þ 1 Never Married 2 Married 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates. 30 Maryland 21215-0036 72 hours after 1 Yes 2 No Specify: Specify: WHITE "natural" Completed 3 Widowed 4 Divorced YRS Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working th and Mental Hygiene. 27 is marked other than ' traumatic event, the Me life. DO NOT use retired) within 7 Elementary/Seconday (0-12) College (1-4 or 5+) 5+ AIR FORCE COLONEL S. Be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည LEWIS THORNBURN THAYER GEORGE JANE FRASER permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any Injury or other traumatic once. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7880 FALCON MEADOW BLVD., PEYTON, CO 80831 JACQUELINE LEWIS / WIFE Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of MARCH 20c. Location - City or Town, State metro crematory or other place)

METRO CREMATORY 1 Burial 2 X Cremation 3 Removal from State 20, 2012 ALEXANDRIA, VA 4 ☐ Donation 5 ☐ Other (Specify) of Funeral Service License 22. Name and Address of Facility RAYMOND FUNL. 22. Name and Address of Facility RAYMOND FUNL. SERVICE, P.A. 5635 WASHINGTON AVE., LA PLATA, MD 20646 MO0641 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ ONGEST 2MONTHS disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner 3 MONALS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine 2 YEARS HRDNIC the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last and Due to (or as a consequence of physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be a within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physicis completed filled in by the funeral director, page 2 should be detached for use as the burn completed filled in by the funeral director, page 2 should be detached for use as the burn. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) Pregnant at time of death Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an ANEMIA autopsy performed? Yes 2 2 No 1 Yes 2 No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2×2 No ျ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 5 Pending injury 1 Natural Accident Investigation 6 ☐ Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar 3510

31. Date filed (Month, Day, Year)

WALDORF,

30. Name and address of person who completed cause of death (Item 23a) (Type, Prings 10 00 WASHINGTOW RD ##

20/2.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			For State		State of M	arylar					and M	lental Hy	gien	е		0.00	
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	Funeral		5. Social Security Nu	mber 6. S	ex 7. Ag		ast birthday)	If Und	r 1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir	rth		9. Birthp	lace (State or F	oreign
	Director		217-56-0	400	□ M 2 X F 6	52	Yrs.	MOTITIS	Days	Hours	IVIII I.	Feb. 2	1,	1950	Mar	yland	
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	or 28	چَ	10e. Street and Num					10f. Z	p Code				10g. C	itizen of Wh	at Coun	try?	
	with s 23a ust b	Funeral Director	16008 Ra	wlings L	ane			2	1557					U.S.	Α.		
	death items		11. Marital Status		12. Was Decedent E Armed Forces?	er in U.						cify Yes or No- Rican, etc.)	-	14. Race -			
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8	within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at	Completed	3 🗆 Widowed 4	15. Decedent's E	Year or Dates.		16a. Decede			tion		-	100				
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pu	be filed ental Hy ked oth ic event	To Be	17. Father's Name (Fi									(First, Middle,					
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Maryland 21215-0036	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		19a. Informant's Nan	ne/Relationship (Ti VanMete			1					Route Number			., _,.	code)	
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Baltimore,	0		1 XBurial 2		Removal from State	0	semetery, cremo ostburg	atory or	other place				ł				
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	Physician/	i K	Immediate Cause (Fi	inal	Car	Les	come		m						-	Onset and Dea	
1	Medical Examiner		resulting in death)		Due to (or as a	a consequ	uence of):				-				7		
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3760	fficate ig phy as the	Med	15.55141.5		u												
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Box 68	death he ath	Physician/M	in the past 12 m 1 Yes 2 9 Unknown	No No	4 Pregnant a g Unknown			Other (s						Month	1	Day Year	r
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E H	an: The tifficat for, pa	Be C	25. Was case referred	to medical					26. Pla	ce of Deat	h (Check	1 L Yes	2	lo 1 L	Yes	2 ∐ No	
Vit	lysici is cer direc	To B	examiner? 1 🗌 Yes 2 🗗	No	Hospital:	ent 2 🗆	ER/Outpatient	3 🗆 C	Other			ne 5 🗆 Resid	dence	6 ☐ Other (Specify)		
Division of Vital Records, P.O.	ng Ph fter th ineral		27. Manner of Death	5 Pending	28a. Date of injui		28b. Time of injury		28c. Injury work?	at	- 1	8d. Describe h					
ion	tendi leath. tor: A: the fu	ifica	2 Accident 3 Suicide	Investigation				М	1 🗆 Y	/es 2 🗆	No						
ivis	or At after of Direct in by	Certificate:	4 Homicide	determined	28e. Place of Inju building, etc			et, factor	y, office		2	8f. Location (8 City or Tox			r Rural i	Route Number,	
Ω	spital ours a leral I		29a. Certifier 1	Tertifying Phys	ician: To the best of	my knowl	edge death or	coured a	the time	date and r	alace and	due to the co	usa(s) 2	nd mannar	o ototo		-
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours affect death. To the Funeral Director, Affect his certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	(Check 2	Medical Exami	ner: On the basis of ex	kaminatior	and/or investig	gation, in	my opinion	, death oc	curred at t	he time, date a	and place	e, and due to	the cau	se(s) and manne	er stated.
	To the within		29b. Signature and tit	tle of certifier	1			29	c. License	number		T	29d. Da	ate signed (A	Aonth, D	ay, Year)	
			•	golle	w ho			7	000	175	65		m	on.	15,	2012	
-	21		30. Name and address		ompleted cause of de	eath (Item	23a) (Type, Pri	int)		1.	11.	10	-	7)	1	-0 -	
0			31. Date filed (Month)		70 71	> /	1351	40	7	U }		-(-	n	U	015	0 -	
	Stat Registra			AP 2 2 20	e Practioner: To the operation of the op	u s signat	1. pa	لعص	,								

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day METHENY MARY ALICE 2012 March 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Garrett County Memorial Hospital 0akland Garrett 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 4/19/1922 Birthplace (State or Foreign Country) 5. Social Security Number Hours Months Days 235-74-0821 89 WV Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location XXYes 2 □ No Director WV Preston Terra Alta 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 26764 57 Cranesville Rd U.S. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ➡ No Specify Specify: White \$ 3 ₩idowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Clothing 8th Seamstress 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Sarah Stanton Smith Fletcher Smith ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 7750 Waterford Dr., Spotsylvania, VA Harold Metheny 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State t☐Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 3/8/2012 Terra Alta, WV Oak Grove Cemetery 22. Name and Address of Facility Arthur H. Wright Funeral Home 105 Highland Avenue, Terra Alta, WV 26764 iphications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or conshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) 11115 Due to (or as a consequence of): Scous fielly list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 23d. Date of delivery 3 Ectopic pregnancy Month Year Day 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 ☑ No 1 ☐Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No

Physician /Medical Examiner Examiner

Physician

/Medical

Examiner

Funeral

Director

show

If item 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, the Medical Evanine must be notified at

Funeral

Be

death with the Maryland

Pages 1 and 2 should be filed within 72 hours after

of Health and Mental Hygiene. item 27 is marked other than

permit. Pages 1
Department of H
Important: If ite
any injury or oti

Baltimore, Maryland 21215-0036

within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-tran Completed

2

Be

Medical Certification: To

3 Suicide

4 Homicide

The law requires that the death certificate be executed

the Hospital or Attending Physician:

To the within 2

Division of Vital Records, P.O. Box 68760,

Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA

27. Manne of Death
1 Natural
2 Accident 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a, Certifier 1 🗂 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

and manner stated.

determined

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, DUNG

29b. Signature and title of certifle

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death . Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ Mckenzi 2455 PM 2012 05 Loger Medical Town, or Location of Death County of Death 4a. Facility Name (if not institution, give street and number) **Examiner** rostbur 2270 OLD PROST BURL If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) g. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 214-52-1367 **Director** 1**X** M 2 □ F Yrs. Maryland March 20, 1950 61 10d. Inside City Limits 28a-f show 10b. County 10c. City, Town or Location 10a. State death with the Maryland Director be notified 1 Yes 2 X No Frostburg MD Garrett 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ò 23a Funeral USA 21532 must 2270 Old Frostburg Rd. items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces? 1 ☐ Yes 2 🔀 No Black, White, etc. ō þ 1 Never Married 2 X Married permit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Exami Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify Specify: White If Yes, Give Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b Kind of Business/Industry MCKenzie Bros. Farming (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Logging & Lumber Co. College (1-4 or 5+) Co-Owner/Operator Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ္ Nellie Garlitz Thomas McKenzie 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2270 Old Frostburg Rd., Frostburg, MD Brenda L. McKenzie/Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State March 10, 2012 Avilton, MD St. Ann Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Newman Funeral Homes, P.A. 21. Signature of Juneral Service Licensee P.O. Box 275, Grantsville, MD 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pan croati Ph_sician/ metastatic disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) executed and Due to (or as a consequence of): attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has performe 1 ☐ Yes 2 ☐ No this certificate filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) æ examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: To 1 🗆 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural within 24 hours after death. To the Funeral Director: After injury 5 Pending 2 🗌 No 1 Tes Accident Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated completely 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one)

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

DHMH 17 Rev 06-2011

Walt Acres Dr. Oa

29d. Date signed (Month, Day, Year)

State Registrar

10

31. Date filed (Month, Day, Year) MAR 0 7 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

Mohammed

Mehmood, 00 9901 Medical center Drive, Rodeville, Maryland 20510 32. Registrar's Signature

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H72163

March 5,2012

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		4	For State	State of Ma	aryland / Dep			vientai Hyg	iene	10	00015
	_		Registrar	Α	Ce	rtificate of D	Jeath	T	eg. No. 🚄 👢	1	09017
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	LAGITIE	CI	Casey House H	ospice (are		ville			ntgor	merv
	Funeral		5. Social Security Number 6. Se		e (In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,		9. Birthp	lace (State or Foreign
b.,	Director			X M 2 □ F	88 Yrs.	IVIOITIIIS Days	Hours Will.	Jan 8		Wasi	mington,DC
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9	or it	by F	1 Never Married 2 X Married	Armed Forces?	No	If Yes, specify Cuba		Rican, etc.)	Bla	ck, White, e	etc.
93	2 hours after death v "natural", or items edical Examiner mu	ed	3 🗌 Widowed 4 🗆 Divorced	If Yes, Give Year or Dates. K	orean	1 ☐ Yes 2 🔀 No	Specify:		Specify	. I	White
21215-0036	72 hours after death with the Maryland "natural", or items 23a or 28a-f sho ledical Examiner must be notified at	Completed	15. Decedent's Ed (Specify only highest gra		16a. Dece	dent's Usual Occupa	ation during most of worl	king	16b. Kind of B	usiness/Ind	dustry
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Maryland	1 and 2 should be filed within 72 f Health and Mental Hygiene. item 27 is marked other than "i other traumatic event, the Med		George Mantzo 19a. Informant's Name/Relationship (Ty		I 19h Mail	ing Address (Street a					Code)
Ĭ	12 sh lith ar 27 is r trau		Carolyn C. Man		46						
ē,	1 and f Hea item othe	ŀ	20a. Method of Disposition		20b. Place of Disp	osition (Name of			20c. Location	_	
E O	Page nent c nt: If ry or		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify			matory or other place Cemeter		08/12	Brool	kevi.	lle, MD
Baltimore,	permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau	1	21. Signature of Funeral Service Licens		2	2. Name and Address	ss of Facility				
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			23a. Part 1. Enter the disease, or comp shock, or heart failure. List only or	lications that caused	I the death. Do not en	ter the mode of dyin	g, such as cardiac	or respiratory arre	st,	,	Approximate Interval Between
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Box 68760	death certificate be ne attending physici ed for use as the bu	2	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome					23d. Da	ate of delive	ery
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ta	sician: The law i certificate has b lirector, page 2 s	Be	25. Was case referred to medical examiner?	Hospital:			ace of Death (Che				
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0 U	ding h. After fune	ate	1 ☑ Natural 5 ☐ Pending	(Month, Da)	v, Year) Injury	work	yai ⟨? Yes 2 □ No	28d. Describe ho	w injury occur	rea	
Sio	Attending Physician: or death. ector, After this certific by the funeral director,	Certificate: To	2 Accident Investigation 3 Suicide 6 Could not be		ury - At home, farm, st		103 2 1140	28f. Location (St	reet and Numb	er or Rural	Route Number,
	al or A s after I Dire		4 Homicide determined	building, etc	c. (Specify)	, ,,		City or Town	, State)		
_	Hospital or 24 hours afte Funeral Din tely filled in	lical			my knowledge, death						
	To the Hospital or Attending Physician: "Thin 24 hours after death as the Funeral Director. After this certification pletely filled in by the funeral director, completely filled in by the funeral director,	Medical	only one) 3 🗆 Certifying Nurs	ner: On the basis of e e Practitioner: To th	xamination and/or inve e best of my knowledg	sugation, in my opinic e, death occurred at t	on, death occurred the time, date and p	at the time, date an place, and due to th	e cause(s) and du	ne to the car manner as s	use(s) and manner stated. stated.
	Vith Vota		29b. Signature and title of certifier			29c. License		2	9d. Date signe		
)		lake	-VY			37142		Mar	ch 3,	, 2012
	K		30. Name and address of person who d	ompleted cause of d							
	J		Geoffrey Cole 31. Date filed (Month, Day, Year)		1355 ar's Signature	Piccard	Dr.,#1	00, Roc	kville	e, MI	20850
	Sta Registr		MAR 0 6 2	119 See 119	m B. 13	barker					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ MORALES LAUDE JOSEPH 11:47 PM 03 201. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MARYLAND MED. CENTER UNIVERSILY BALTIMORE al If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours Min. (Month, Day, Year) **Director** 437-52-5491 1 XM 2 □ F 06/29/1938 LA 73 Usual Residence of Decede Show 10a. State 10b. County 10d. Inside City Limits ms 23a or 28a-f short must be notified at 10c. City, Town or Location with the Maryland Director 1 X Yes 2 No MILLINGTON MD KENT 10e Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 184 SASSAFRAS STREET 21651 UNITED STATES items death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian the Medical Examiner Armed Forces?

1 X Yes 2 No If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. ò 1 Never Married 2 X Married þ Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 X No Specify: "natural", Completed 3 Widowed 4 Divorced Year or Dates WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) AUTOMOTIVE MANUFACTURING 12 ASSEMBLYMAN Be Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည CLIFTON MORALES EMMA LEE LABLEAU 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) EDIE MORALES / WIFE 184 SASSAFRAS STREET MILLINGTON, MARYLAND 21651 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) ASBURY CEMETERY 03/09/2012 MILLINGTON, MARYLAND 21. Signature of For eral Service Licen 22. Name and Address of Facility
FELLOWS, HELFENBEIN AND NEWNAM FUNERAL HOME,
370 W. CYPRESS ST. MILLINGTON, MARYLAND 21651 tar 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Ph. sician/ a COMPLICATIONS of Toxic MEGACOLON Medical resulting in death) Due to (or as a consequence of) Examiner Section tially list conditions if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) been signed by the s 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ PNEUMONIA 1 ☐ Yes 2 📈 No 3 ☐ Probably 4 ☐ Unknown Be Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy perform 1 Yes 2 No 1 ☐ Yes 2 🗷 No this certificate filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 1 Inpatient 2 I ER/Outpatient 3 I DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 1 🔲 Yes 2 🔲 No 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completely filled in by the funer injury 1 X Natural 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗆 only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 03/03/2012 1376868281 30. Name and address of person who completed cause of death (Item 23a) (Type, Print Of MARYLAND DANIEL MEDINA UNIVERSITY MEDICAL

DHMH 17 Rev 06-2011

Registrar

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 4a, per phy 10e, 12, 19b, per fh, g925 3-29-12 sm State of Maryland 7 Department of Health and Mental Hygiene Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 5-Day 2012 Year Physician/ William Lester Maynor Month 5:28 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death **Place** PG 8906 Dangerfield Road Clinton Social Security Number 6. Sex If Under 1 Year I If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 🕱 M 2 🗌 Months Hours 557-50-0835 (Month, Day Yea Country) DC Director 74 Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10b. County 10a. State and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director MD PGClinton 1 H Yes 2 □ No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8906 Dangerfield Road US 20735 **Place** 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian traumatic event, the Medical Examiner Black, White, etc. 1 Never Married 2 🔀 Married ō þ Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔼 No 3 Widowed 4 Divorced "natural" Specify: Black Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Treasurer Employee Government 12thBe 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Elizabeth Taylor Willie Maynor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8906 Dangerfield Road, item 27 i Brenda Maynor/Wife Clinton, MD 20735 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1 a
Department of H
Important: If ite
any injury or ot Page 1 1 🐰 Burial 2 □ Cremation 3 □ Removal from State 3-10-2012 Suitland, MD 4 ☐ Donation 5 ☐ Other (Specify) incoln Memorial 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Pope Funeral Homes, P.A. M00981 Charles Ë 5538 Marlboro Pike, Forestville, MD 20747 23a. Part 1. Enter the disease, or complications that caused the disease, both as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ Hypertension Medical Due to (or as a consequence of) Examiner Chronic Kidney Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): burial-transit Cause (Disease or iinjury Rheumatoid Arthritis that initiated events resulting in death) Last and attending physician Physician/Medical requires that the death certificate be Prostate Cancer P.O. Box 68760 as the IF FEMALE yes, outcome of pregnancy
Live Birth 2 Fetal death nse 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) for in the past 12 months? Month Year Pregnant at time of death been signed by the a should be detached to Yes 2 No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 1 ☐ Yes 2 x No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an or Attending Physician: The law autopsy performed? Yes 2 death? certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 X Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 IDOA To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director; After this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28d. Describe how injury occurred 28c. Injury at Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation filled in by the 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier сотріете (Check only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MUC 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rupa A. Varma, 1221 Mercantile Lane, Largo, MD 20774 M.D 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2012 arko Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Month 201 MARY MARGUERITE MILSTEAD MAILC 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death HARL VISTA MEDICAL If Under 24 Hrs Birthplace (State or Foreign MD If Under 1 Year 8 Date of Birth 7. Age (In vrs. last birthday) 1 □ M 2 😾 F Months Days Min Month, Day, Year 30 Hours 578-40-8323 81 Yrs Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD. CHARLES BRYANS ROAD 1 🗆 Yes 2 📈 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6764 AMHERST ROAD 20616 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc 1 Never Married 2 Married 1 ☐ Yes 2 XNo Specify: Specify: WHITE 3 ▼ Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) HOMEMAKER OWN HOME 10th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) RAPHEL WALLACE BURCH RUTH VIRGINIA WELCH 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6764 AMHERST RD. BRYANS ROAD, MD. CHARLES MILSTEAD-SON 20616 20b. Place of Disposition (Name of cemetery, crematory or other p 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CHICAMUXEN CEM. 3-17-12 CHICAMUXEN, MD. 21. Signature of Funeral Service Licens 22. Name and Address of Facility MO0479 RAYMOND FUNERAL SERVICE, P.A. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ventoulant Due to (or as a consequence of) Sequentially liet con ditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): that initiated events Due to (or as a consequence of) resulting in death) Last IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month Day Year 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed death? 1 Yes 2 No Yes 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 XNO 1

Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury at 28d. Describe how injury occurred ✓ Natural

Examiner Examine physician a s the burial-1 Physician/Medical the attending ploched for use as the þ certificate has been signed I irector, page 2 should be det Completed by Be မှု this Certificate: within 24 hours a

To the Funeral [Medical

Physician: The law requires that the death certificate be executed

Division of Vital Records,

To the Hospital or Attending

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ıral", or items 23a or 28a-f shov Examiner must be notified at

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Physician/

Medical

within 72 hours after death with the Maryland

Maryland 21215-0036

Baltimore,

MAR

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25. Was case referred to medical examiner? 27. Manner of Death

☐ Accident ☐ Suicide

4 Homicide

29a. Certifier (Check

5 Pending Investigation 6 Could not be determined

28a. Date of injury (Month, Day, Year) 28b. Time of injury 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 🗌 Yes 2 🗀 No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

35 MI C

State Registrar

29b. Signature and title of certifier

DHMH 17 Rev 7/2009

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	٥	1 Never Marr		ried 1 Arme	ed Forces? Yes 2 s, Give or Dates.			f Yes, specify Cub	an, Mexic	an, Puerto	Rican, etc.)			White, e	etc.
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DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For AMEND#18 per FH State of Maryl State 3/6/2012 AACO HEALTH DEPT. CMH Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death March Physician/ 2012 John H. Petrini 3:57 A M Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number, 4c. County of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Days 213-64-1251 1 🖾 M 2 🗆 F 61 **Director** 1950 31. Maryland Usual Residence of Decedent 28a-f shov 10b. County 10d. Inside City Limits 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 10a, State 10c. City. Town or Location Director Maryland Anne Arundel Annapolis XX Yes 2 No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21403 Funeral 1 Walton Lane U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. ģ 1 Never Married 2 KM Arried Baltimore, Maryland 21215-0036 filed within 72 hours after Specify: White 1 Yes 2 No Specify: Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) 12 College (1-4 or 5+) should be filed within and Mental Hygiene. Musician/Marina Owner Self-employed Be 17. Father's Name (First, Middle, Last)
Edgar J. Petrini 18. Mother's Name (First, Middle, Maiden Sumame)
- Carmalla Schall Carmella Schall ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
P.O. Box 3061 Annapolis, Maryland 21403 19a. Informant's Name/Relationship (Type, Print) Judith Dodge-Petrini/wife and 2 s Health a other tem 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Page 1 a
Department of H
Important: If ite
any injury or ott 1 Burial 2 K Cremation 3 Removal from State Baltimore Crematory 3/7/2012 Baltimore, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility John M. Taylor Funeral Home 21. Signature of Funeral Service Licens 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially fist conditions, Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury attending physician and for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death ate has been signed by the a page 2 should be detached 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 3 Probably 4 ☐ Unknown Division of Vital Records, 1 Yes 2 No Completed 24b. Were autopsy findings available 24a. Was an autopsy performed? Yes 2 No prior to completion of cause of death? 1 Yes 2 No director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ျှ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at ne Hospital or Attending Pl n 24 hours after death. ne Funeral Director; After th 28d. Describe how injury occurred Certificate: 5 Pending 1 Yes 2 No Accident Investigation completed filled in by the 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the within 2 only one 29b. Signature and title of certif D 24864 3/3/12

AAMC Annapolis Med 2140/ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Terson 31. Date filed (Mor State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 2012 Physician/ March 2340 Louise H. Parker Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Washington Adventist Hospital Takoma Park Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) Funeral Hours Months 240-40-9368 1 □ M 2 🕇 F Director 1924 North Carolina April 3, 87 Usual Residence of Decede 28a-f show 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State within 72 hours after death with the Maryland must be notified at **Funeral Director** 1 X Yes 2 No Washington DC 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ō items 23a 20001 United States 1555 4th Street NW 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🍱 No 14. Race - American Indian 11. Marital Status Examiner Black, White, etc. 5 þ 1 Never Married 2 Married African Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify. If Yes, Give "natural" Completed 3 🛚 Widowed 4 🗌 Divorced American Year or Dates. e 1 and 2 should be filed within 72 hours of Health and Mental Hygiene. If item 27 is marked other than "natun or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Private House Keeper 3rd Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Kathie Hayes Sidney Moore 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1555 4th Street NW #1 Washington, DC 20001 Cynthia Parker Brice - Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition March 16, Department of Important: If it any injury or o 1 X Burial 2 Cremation 3 Removal from State 2012 Suitland, Maryland Cedar Hill 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licer 22. Name and Address of Facility Stewart Funeral Home, John awart Washington, DC 20019 4001 Benning Road NE 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate as a consequence of) Examine cause. Enter Underlying To the Hospital or Attending Physician; The law requires that the death certificate be executed the burial-transit Cause (Disease or injury that initiated events 4577 R and Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical DEMANTIA Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy signed by the atter in the past 12 months?

1 Yes 2 No Month Year Day 5 Other (specify) Pregnant at time of death g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy has perform 1 Yes 2 No certificate Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 1 SInpatient 2 ER/Outpatient 3 DOA မ this funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Certificate: within 24 hours after death.

To the Funeral Director: After to ompletely filled in by the funer injury 1 Natural 5 Pending Accident Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) 2012

State

Registrar

Randall Wagner 31. Date filed (Month, Day, Year)

30. Name and address of person who completed

death (Item 23a) (Type, Print)

Sarroll Avenue

32. Registrar's Signatur

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7600

D 4495

Takoma Park, Maryland

MAZCH

20912

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 12-02011 State of Maryland / Department of Health and Mental Hygiene Sheryl Ann Quillen Certificate of Death 1- For State Reg. No. Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month 10, 2012 0135 hrs Medical Examiner SHERYL ANNE QUILLEN 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Anne Arundel Annapolis 2 Old Mill Bottom Road North 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 5. Social Security Number **Funeral** oreign Hours Months Davs Director NEW JERSEY 49 Yrs 2**X** F 1 M 07/01/1<u>962</u> 219-62-9406 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b, County 10a, State 1 Yes 2 No permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a nr 28a-f she injury or nther traumatic event, the Medical Examiner must be notified at once ANNAPOLIS ANNE ARUNDLE Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number UNITED STATES 21409 OLD MILL BOTTOM ROAD 13. Was Decedent of Hispanic Origin? (Specify Yes or No 14. Race - American Indian, Black, uneral 12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 Never Married 2 Married 2 X No Yes If Yes, Give Year or Dates: Specify: WHITE 1 Yes 2 X No specify: 3 Widowed 4 X Divorced 6 16a. Decedent's Usual Dccupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) MD 21215-0036 HEALTH CARE CAREGIVER 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be DONNA CATHERINE PRICE JAMES ALLEN FENSKE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) P.O. BOX 284 MILLINGTON, MARYLAND 21651 DEBORAH STELLER / SISTER 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 20a. Method of Disposition Itimore, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State CHESAPEAKE CREMATION 03/13/2012 STEVENSVILLE, MARYLAND Donation 5 Other Specify 22. Name and Address of Facility
FELLOWS, HELFENBEIN AND NEWNAM FUNERAL HOME, 21. Signature of Funeral Service Licenses 130 SPEER ROAD CHESTERTOWN, MARYLAND Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and failure. List only one cause on each line Death /Medical a Hypertensive Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions Due to (or as a consequence of) if any leading to immediate cause. Enter Underlying Cause Exami (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last After this certificate has been signed by the attending physician and uneral director, page 2 should be detached for use as the burial - transi Physician/Medical AMENDED 23a,27,per me,g925 3-23-12 sm **X** UNPENDED Box 68760, 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Dav Year 1 Live birth Fetal death Pregnant at time of death 5 Other (Specify) 1 Yes 2 V No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. <u>\$</u> 1 Yes 2 No 3 Probably 4 V Unknown Completed 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of death? 2 No Yes 2 No 1 🗸 Yes 26.Place of Death (Check only one) 25. Was case referred to medical Hospital nr Attending Physician: 24 hours after death. funeral director, Division of Vital Be examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other₄ Nursing Home 5 Residence 6 🗸 Other: Scene 1 V Yes 2 No 28d. Describe how injury occurred 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death Certification: 1. X Natural 1 Yes 2 No filled in by the fi Pending Investigation Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Suicide Could not be To the Hospital I. within 24 hours af To the Funeral D determined Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 1 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

and and

DHMH 17 Rev 1/2001 OCMF 2006

State

Registra

30. Name and address of person who completed cause of death (Item 23a)

2012

Jack Titus MD. Det

Debuty Chief Medical Examiner

Registrar's Signat

O.C.M.E.

900 W. Baltimore Street, Baltimore, MD 21223

March 10, 2012

12-01972

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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Raul Alberto Rosales, Jr.	State of Maryland / Department of Health and Menta

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Medical Examin	er	Raul	Albe	rto Re	osales				!	March 8, 2	012	of Dooth	14151115
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Salti ermit. epartn mport	Ī	21. Signature of Funeral	Service Licer	9		15 H	ame and Address	KINA	TDI	FUNE	RAL SE	RVI	CE,P.A. ng,Md20910
	4	23a. Part I. Enter the dis	ease or comp	lications that caused	the death. Do	92 not enter th	e mode of dying,	such as car	rdiac or re	espiratory arre	est, shock, or he	art	Approximate Interval
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Division of Vital Records, P.O. vithe Hospital or Attending Physician: The law requires that within 24 hours after death. To the Funeral Director: After this certificate has been signed to completely filled in by the funeral director, page 2 should be detailed.	Certification:	2 Accident 3 Suicide 6	Could not	be 28e. Place of	Injury - At hom	e, farm, stree	et, factory, office b	uilding, etc	2	8f. Location (S or Town, S		oer or Ru	ral Route Number, City
Ospital hours nneral		4 Homicide 29a. Certifier (Check only 1 Cert		ian: To the best of r	ny knowledge	death occur	red at the time. da	ate and place	ce. and d	ue to the caus	se(s) and manne	er as stat	ed.
To the Hos within 24 h To the Fun	Medical	(Check only one) 2 Med	tical Examine	r:On the basis of ex	amination and	or investigat	tion, in my opinion	, death occ	curred at	the time, date	and place, and	due to th	e cause(s)
		29b. Signature and title	of certifier	and manner stated			29c. Licens	e number			29d. Date sig	ned (Mo.	nth, Day, Year)
1- Per	>	('ere	de	Hell	au	-	O.C.	M.E.			March 9, 2	2012	
		30. Name and address		completed cause of	death (Item 23	3a) 00 W. Bal	timore Street	Baltimo	re, MD	21223			
		Carol Allan, ME 31. Date filed (Month, D	ay, Year)		rar's Signature								
Regist	rar	MAG	1 6 201	1 Xbarre	4 4.	Mary.							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day 2012 Shirley Ann Reiter March 3, 12:10 a M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Taneytown Lorien Nursing & Rehabilitation Ctr Carroll Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 M 2 X F Months (Month, Day, Hours 76 Maryland Director 215-30-9170 1935 Mar Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits Director or 28a-f sh notified a Carroll Taneytown Maryland 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 6 10g. Citizen of What Country? must be 210 Clubside Drive 21787 Funeral permit. Page 1 and 2 should be filed within 72 hours after death with 23a USA "natural", or items dical Examiner mu 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married ρ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates white Specify. 3 Divorced Completed the Madical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) ntal Hygiene. ed other than event, the M College (1-4 or 5+) Food Distributor Food Preparation Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ith and Mental H 27 is marked of traumatic ever 2 Frank Novak Ella Manley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1251 S Pleasant Valley RD, Westminster, MD 21158 Darlene Zeiler, daughter of Health 27 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ★Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 6 Department of Important: If any injury or 3/6/2012 Westminster, MD Meadow Branch Cem. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Myers-Durboraw Funeral Home 91 Willis Street, Westminster, MD 21157 20a, Part 1/2 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between ock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Ph sician/ disease or condition resulting in death) Medical Examiner Disquentially first conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) the attending physician and hed for use as the burial-transit Due to (or as a consequence of): certificate be Box 68760 IF FEMALE: ves, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregna
5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 L retail L
Pregnant at time of death Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Day signed by the a d be detached for 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by or Attending Physician: The law requires 2 No 3 Probably 4 Unknown To the Hospital or Attending Physician: The law requires within 24 hours after death.

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1 Yes 2 No Be 26. Place of Death (Check only one) Hospital: Other: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural 5 Pendina Accident Investigation M Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

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State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Physician/ 2 I Day FEB 2012 4:28 Рм ROSENBAUM NATHAN DYLAN Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MONTGOMERY **BETHESDA** WRNMMC 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** February 21 Country 1 **₹** M 2 □ F Months **Director** Usual Residence of Decedent 28a-f show 10a. State 10d. Inside City Limits with the Maryland 10c. City, Town or Location Director traumatic event, the Medical Examiner must be notified 1 Yes 2 X No Pr. William Co Haumarket VA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō Funeral 23a 6453 Ashby Grove Loop 20169 items ? permit. Page 1 and 2 should be filed within 72 hours after death \
Department of Health and Mental Hyglene.
Important: If item 27 is marked other than "natural", or items
any hiury or other traumatic event, the Medical Examiner mu
once. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No 11 Marital Status 14. Race - American Indian Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Completed by 1 X Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: White 3 Wldowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) N/A Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Kimberly Williams Shawn Rosenbaum 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kimberly Rosenbaum (mother) 6453 Ashby Grove Loop, Haymarket, VA 20169 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date cemetery, crematory or other place, Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 3/6/2012 Falls Church, VA National FH & Crematory anature of Funeral Service Licensee 21 22. Name and Address of Facility Murphy Falls Church Funeral Home 1102 W. Broad St., Falls Church, VA 22046 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) HYPOXIA ISCHEMIA Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Pregnant at time of death Other (specify) the 9 Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒No 24a. Was an autopsy performed this certificate has ral director, page 2 Yes 2 No Be (25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: ၉ 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 28d. Describe how injury occurred After 1 🔀 Natural 5 Pending within 24 hours after death.

To the Funeral Director: Air completed filled in by the fu 2 🗌 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 [only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0101235481 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WRNMMC, BETHESDA, MD 20889 LCDR MC USN PETERSON filed (Month, Day, Year) 32. Registrar's Signature State

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Registrar

MAR 0 8 20

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical 4b. City Town, or Location of Death lame (if not institution, give street and number) Examiner Hole Hagels ONA If Under 1 Year Ulf Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) Social Security Number 6. Sex **Funeral** Min. 1 M 2 Months Days Hours Director 026-20-7834 89 8/20/1922 Massachusette Usual Residence of Decedent show 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State the Maryland t Director or 28a-f sh notified 1 Yes 2 No MD Washington Hagerstown 10a, Citizen of What Country? 10f. Zip Code 10e. Street and Number ò must be i Completed by Funeral with 1 21742 14138 Tarheel Court permit. Page 1 and 2 should be filed within 72 hours after death v. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "nature." any injury or other transmire. 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 🗆 Yes 2 No Specify Specify 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Publishing 12 Sewing Machine Operator 18. Mother's Name (First, Middle, Maiden Surname) Be 17. Father's Name (First, Middle, Last) ပ Gertrude Blair Grant Shampo 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Robin Lee / Daughter Hagerstown Tarheel Court. MD 20c. Location - City or Town, State 20a. Method of Disposition
1 ☐ Burial 2 ★ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of Date cemetery, crematory or other place) Smithsburg Crematory 3/17/2012 Smithsburg, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Rest Haven Funeral Chapel Signature of Juneral Service Lice 1601 Pennsylvania Ave., Hagerstown, MD 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause a each line. Onset and Death Immediate Cause (Final Ph sician/ disease or condition resulting in death) aconaly Medical Due to (or as a consequent e of) Examiner Sequentially list conditions, Examiner Due to for as a consequence of if any, leading to immedicause. Enter Underlying Cause (Disease or linjury and that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death 5 Other (specify) signed by the aid be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed page 2 should peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 X No has 1 ☐ Yes 2 ☐ No 24 hours after death. Funeral Director: After this certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one) completed filled in by the funeral director, Be Other: Hospital: 2 No 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: To 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at work? 1 ☐ Yes 2 ☐ No Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending Investigation Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Homicide determined Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifie (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F only one) 29d Date signed (Month, Day, Year) 29b. Sigpeture and title of certifier 29c. License number 30 Name and address of person who completed couse of death (Item 23a) (Type, Print Stopped Concord Con stephenic STOWN 31. Date filed (Month, Day, Year) State

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Registrar

2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		1	For State O' State Registrar	Maryland / Depa <i>Cer</i>	artment of He tificate of De			ene _{g. No.} 20	12 09027
	Physicia		Decedent's Name (First, Middle, Last)				2. Date of Death		3. Time of Death 2012 11:15 A M
	Medic Examin	al .	JANET BEVERLY SMITH Aa. Facility Name (if not institution, give street and num	ber)	4b. City, Town, or Lo		HAROH	4c. County	
			QUEEN ANNE'S COUNTY HOSP		CENTREVI			QUEE	EN ANNE'S
	Funeral Director		5. Social Security Number 6. Sex 1 ☐ M 2 🗓 F	7. Age (In yrs. last birthday) 65 Yrs.		f Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,) 07/07/19		9. Birthplace (State or Foreign Country) PENNSYLVANIA
0			Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Loc	cation		0//0//13	740	10d. Inside City Limits
	larylan 3a-f sh ified a	Director	MD PRINCE GEORGE'S						1 🛣 Yes 2 🗆 No
	a or 28	ig	10e. Street and Number		10f. Zip Code		10	og. Citizen of W	Vhat Country?
	ms 23 must	Funeral	1-C LAUREL HILL ROAD	dent Ever in U.S. 13. V	20770		cify Yes or No-		STATES e - American Indian,
Maryland 21215-0036	1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	þ	11. Marital Status 1 □ Never Married 2 □ Married 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced 12. Was Dece Armed For 1 □ Yes, Giv. Year or Da	2 🔼 No	Was Decedent of Hispa f Yes, specify Cuban, I I ☐ Yes 2 💢 No		Rican, etc.)	Blaci	k, White, etc. WHITE
15-0	72 hou "natu ledical	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give i	dent's Usual Occupation kind of work done duri O NOT use retired)	on ing most of workin	ng	16b. Kind of Bu	usiness/Industry
212	within giene. er thar , the N		Elementary/Secondary (0-12) College (1-10)	4 or 5+)	DUCTION WO	RKER		FULFIL	LMENT
pue	e filed tal Hy ed oth event	To Be	17. Father's Name (First, Middle, Last) GILBERT DANIEL FISHER		11	8. Mother's Name	e (First, Middle, Ma CATHRYN E)
ary S	should b and Mer is mark raumatic		19a. Informant's Name/Relationship (Type, Print)	19b. Mailir	ng Address (Street and				tate, Zip Code)
	and 2 sh Health ar em 27 is ther trau		TERESA ANN PURDY / DAUGI		MAIN STRE	ET, QUEE			
Baltimore,	Page nent c int: If ry or		20a. Method of Disposition 1 ☐ Burial 2 🏿 Cremation 3 ☐ Removal from 4 ☐ Donation 5 ☐ Other (Specify)	State CHESAPEAK CEN	esition (Name of matory or other place) E CREMATIO TER	N 03/07			City or Town, State VILLE, MD
Ball	permit. F Departm Importa any inju		21. Signature & Funeral Service Livenes	F:	06 SHAMROC	LFENBEIN K ROAD	CHESTER	MD 21	RAL HOME, P.A.
			23a. Part 1. Enter the disease, or complications that coshock, or heart failure. List only one cause on ea	aused the death. Do not ente	er the mode of dying,	such as cardiac o	r respiratory arres	st,	Approximate Interval Between Onset and Death
)	Physician/ Medical			ASTATIC COLON	CANCER				
	Examiner	Ļ	Sequentially list conditions, b.						
	ed sit	Examiner	if any, leading to immediate cause. Enter University Cause (Disease or injury	or as a consequence of):					
	execut an and rial-trai	Еха	that initiated events C.	or as a consequence of):					
2097	sate be executed physician and s the burial-transit	edical	d						
Box 687	ath certific at ending for use as	Physician/Me	in the past 12 months?	nant at time of death 5	Ectopic pregnancy Other (specify)			23d. Dat Mo	te of delivery nth Day Year
ls, P.O.	requires that the des been signed by the s should be detached	by	Part II. Other significant conditions contributing to d	eath but not resulting in the u	underlying cause giver	n in Part I.			ribute to the cause of death?
Division of Vital Records,	The law requate has been page 2 shou	Completed					24a. Was ar autops perform 1 \(\subseteq \text{Yes} \) 2	y ned?	Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No
ital	ysician: The la s certificate ha director, page	Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital:		Other:	e of Death (Check	k only one)	ν HO	SPICE CENTER
n of V	Attending Physic death. ector; After this by the funeral di	cate: To	27. Manner of Death 28a. Date	Inpatient 2 ☐ ER/Outpatie of injury th, Day, Year) 28b. Time o injury	f 28c. Injury a work?	at Nursing Ho	28d. Describe ho	w injury occurr	er (Specify) ed
Divisio	To the Hospital or Attending I within 24 hours after death. To the Funeral Director; After completely filled in by the fune	Certificate:	3 Suicide 6 Could not be	of Injury - At home, farm, str ng, etc. (Specify)	reet, factory, office		28f. Location (Str City or Town		er or Rural Route Number,
	he Hospit in 24 hour he Funera ipletely fille	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the bar only one) 1 Medical Examiner: On the bar of the bar	sis of examination and/or inves	stigation, in my opinion,	, death occurred at	t the time, date and	d place, and du	e to the cause(s) and manner stated.
	Vith To t		29b. Signature and title of certifier		29c. License n		2		d (Month, Day, Year)
	4x		30. Name and address of person who completed caus	se of death (Item 23a) (Type,	D6374	1		3/6/	12
	שון		JEFFREY L. UKENS,	MD 2540 CEN	TREVILLE R	OAD, CEN	TREVILL	E, MD 2	1617
	Sta Registr		31. Date filed (Month Day Year) 7 2012 32. F	distrar's Signature	park				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day} 2012 Physician/ PAULA KAY STINE MARCH Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK Social Security Number 6. Sex . Age (In yrs. last birthday) **Funeral** If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign 1 M 2X F Hours 218-50-4743 0 (Menth, 30 Year) 1949 Maryland **Director** Yrs Usual Residence of Decedent 28a-f show ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d, Inside City Limits Director Maryland Frederick Frederick 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21702 USA 1421 Taney Avenue 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married ģ 2X No 1 Yes If Yes, Give Maryland 21215-0036 white 1 ☐ Yes 2XXNo Specify: Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Court House and record clerk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Richard Charles Kline Catherine Betty King 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Fraderick Marvland 21702 19a. Informant's Name/Relationship (Type, Print) ge 1 and 2 sl it of Health a 1421 Taney Avenue, Frederick, Maryland Wayne L. Stine, Sr. - husband Baltimore. 20a. Method of Disposition permit. Page 1 a
Department of H
Important: If ite
any injury or oth 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Stauffer Crematory 3-7-2012 Frederick, Maryland Signature of Funeral Service Licenses 22. Name and Address of Facility Stauffer Funeral Home 1621 Opossumtown Pike, Frederick, Maryland 3a. Part 1. Enter the disease, or or plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one caure Interval Between Immediate Cause (Final letastatic Onset and Death Physician/ Endoneono disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or impury that initiated events Due to for all a gensequence of death certificate be executed and -tran: that initiated events resulting in death) Last Due to (or as a consequence of) burial Physician/Medical Box 68760 phy: the IF FEMALE JSe 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 23d. Date of delivery atter 3 Ectopic pregnancy
5 Other (specify) for Month Pregnant at time of death 1 Yes 2 the a P.O. signed by to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>م</u> Records, 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy Hospital or Attending Physician: The L24 hours fler death.
Funeral Director After this certificate heted filled in by the funeral director, page performed? Yes 2 V 1 Yes After this certification funeral director, p 25. Was case referred to medical Division of Vital 26. Place of Death (Check only one) Be examiner? 2 **X**No 1 Yes Other: ဂ Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending Accident Suicide 1 Yes Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier соmpleted within 2 To the F 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29d. Date signed (Month, Day, Year) who completed cause of death (Item 23a) (Type, Print) Mo 400

DHMH 17 Rev 7/2009

State Registrar 32. Registrar's Signature

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ MARCH 0403 M 2012 Medical give street and numb 4c. County of Death Facility Name (if not institution, Town, or Location of Death **Examiner** eny IVE estertown If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Security Number **Funeral** 1 🗆 M 2 🗶 Days Hours Min. MARYLAND 10/20/193 80°s Director 215-26-4851 Usual Residence of Decedent 28a-f shov 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State aţ filed within 72 hours after death with the Maryland **Funeral Director** remarked other than "natural", or items 23a or 28a-f s traumatic event, the Medical Examiner must be notified 1 Yes 2 X No MD QUEEN ANNE'S CHESTERTOWN 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 209 WARWICK DRIVE UNITED STATES <u> 21620</u> 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Was Deces? Armed Forces? □ Yes 2**X** No Black, White, etc ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No If Yes, Give Year or Dates Specify. Completed 3 X Widowed 4 Divorced WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) BANKING BANK TELLER Be permit. Page 1 and 2 should be file.
Department of Health and Mental Hilmportant: If item 27 is morning injury or other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ MARY KATHERINE KENNARD CHARLES THEODRICK MCCLARY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) RON SCHAUBER / SON 237 WARWICK DRIVE CHESTERTOWN. MARYLAND 21620 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) PAUL'S CEMETERY 03/09/2012 CHESTERTOWN, MARYLAND Name and Address of Facility
LLOWS, HELFENBEIN AND NEWNAM FUNERAL HOME, P.A.
O SPEER ROAD CHESTERTOWN, MARYLAND 21620 Signature of Funeral Service License 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Phylician/ disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of) attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant ☐ Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month igned by the atte be detached for Year Day Other (specify) Pregnant at time of death Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 2 No 3 Probably 4 Unknown Certificate: To Be Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy page 2 perform death? 1 Yes 2 No Yes 25. Was case referred to medical 26. Place of Death (Check only one) the funeral director, examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 Inpatient 2 ER/Outpatient 3 DOA this Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at work? 1 Yes 28d. Describe how injury occurred within 24 hours after death. To the Funeral Director: After 1 Natural 5 Pending injury 2 🗆 No Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide filled in by determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed (Check only one) 29b. Signature and title of certifie who completed cause of death (Item 23a) (Type, Print) Name and address of CHESTERTOWN 21620 46035 200 Date filed (Month, Day, Registra State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Physician/ Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Examiner Anne Arundel Harwood Mandrin House If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign If Under 1 Year Social Security Number 7. Age (In yrs. last birthday) **Funeral** (Month, Day, Year) Days 212-30-8722 1 M 2 D F 76 Director 5/11/1935 MD Usual Residence of Dec 28a-f show 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shor any injury or other traumatic event, the Medical Examiner must be notified at 10b. Count 10c. City, Town or Location Director 1 Yes 2XXNo Annapolis MD Anne Arundel 10g. Citizen of What Country? 10f. Zip Code Oe. Street and Numbe Funeral 21403 USA 1814 Glade CT. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11 Marital Status Black White, etc. Armed Forces? XX Yes 2 No 1954-If Yes, Give δ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 Yes 2 XXIo Specify. 3 Widowed 4 Divorced Completed 1957 Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) Photographer Photography Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Lillian Horowitz William Stearns 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1139 Claire Rd. Crownsville, MD 21032 Jay Stearns 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Exercial 2 Cremation 3 Removal from State 4 Dbnation 5 Other (Specify) Maryland Veterans Cem 3/6/2012 Crownsville, MD 22. Name and Address of Facility 21. Signat Hardesty Funeral Home, P.A. 12 Ridgely Ave. Annapolis, MD 21401 Pa. 1. Enter the divease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shipck, or hearlifature. List only one cause on each line. Approximate nterval Betweer e ate Cause (i eas o or conditi nset and Death Ph_sician/ Medical resulting in death Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Exam the Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-tran Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 nding | IF FEMALE yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 - Fetal death 3 Ectopic pregnancy for L in the past 12 months? 5 Other (specify) Pregnant at time of death 1 Yes 2 No detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Be Completed by 2 ☐ No 3 ☐ Probably 4 ☐ Unknown this certificate has been sival director, page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 1 Yes 2 No 25. Was case referred to medical examiner?

1 Yes 2 No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 2 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Medical Certificate: After Natural 5 Pending 1 Yes 2 No Accident Investigation within 24 hours after death

To the Funeral Director:

completely filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 0

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State Registrar iled (Month Day Year) is 2012 32. Registrar's Signature

who completed cause of death (Item 23a) (Type, Print

DEFENSE HWY ANNAPOLIS M.D.2140

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Medical County of Death
Anne Arundel 4a. Facility Name (if not institution, give street and number, Town, or Location of Death **Examiner** Harwood Mandrin House If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Social Security Number last birthday 6. Sex **Funeral** 77 252-52-9588 Director 1 M 27 GA 11/28/1934 show 10d. Inside City Limits 10c. City, Town or Location 10a. State permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland iral", or items 23a or 28a-f sho Examiner must be notified at Director 1 ☐ Yes 🍇 🛣 No 0denton MD Anne Arundel 10f. Zip Code 10a. Citizen of What Country? 10e. Street and Number Funeral USA 21113 1192 Winer RD. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Race - Alba... Black, White, etc. White 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 XX arried 2 Baltimore, Maryland 21215-0036 1 Yes XX No If Yes, Give Year or Dates "natural", 3 Widowed 4 Divorced Completed of Health and Mental Hygiene. item 27 is marked other than "natur other traumatic event, the Medical I 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) Education Teacher Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ္ Mary Phillips Francis Mott Henry 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1192 Winer Rd. Odenton, MD 21113 Husband Ralph Steele 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of H Important: If ite any injury or ot once, 1 🔀 urial 2 🗆 Cremation 3 🗀 Removal from State Gracelawn Memorial Park 3/6/2012 New Castle, DE 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Sovice Licensee 22. Name and Address of Facility Hardesty Funeral Home, P.A. Annapolis, MD 21401 78 12 Ridgely Ave. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Inset and Dirach Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events use as the burial-tra Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months' 1 Yes 2: No Year Month ò Dav Pregnant at time of death been signed by the sahould be detached 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page 2 performed 1 ☐ Yes 2 ☐ No certificate 1 Yes 2 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital ANDRIX 1 ☐ Yes 2 ☐ No 2 1 Inpatient 2 I ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 this USC s after death.
al Director: After th . Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1-10 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending injury 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours after
To the Funeral Directormpletely filled in b Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Netical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Deertifying Nurse Practitioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier

State Registrar

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30 Name and address of person who

MAR 06 2012

EFENSE HWY

completed cause of death (Item 23a) (Type, Print)

OR

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 39 am arch Stella Maxine Snyder Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Ned La charle. ICA (ente Birthplace (State or Foreign Country) If Under 8. Date of Birth If Under 24 Hrs. . Age (In vrs. last birthday) **Funeral** Min (Month, Day, Year) 577-30-0670 **Director** 1 🗆 M 2🗶 F Dec. 3, 1924 VA. 87 Usual Residence of Decedent or 28a-f show notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Waldorf Charles 1 X Yes 2 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? ō ms 23a or must be r Funeral 3605 Moses Way 20602 United States Apt. 210 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or item ledical Examiner r Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. þ 1 Never Married 2 Married Yes 2 X No If Yes, Give Year or Dates 1 ☐ Yes XX No Specify: 3 Widowed 4 □ Divorced Specify: Completed White Medical 15. Decedent's Education 16a. Decedent's Usual Occupation Maryland 21215-16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) the 10 Owner/Self Employed Store Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Ada Householder Clark Anderson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Important: If item 27 any injury or other tra Mary Curry (Daughter) 1810 Cooper Ct. Waldorf, MD. 20602 Itimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State Date 3/9/2012 Shenandoah Memorial Winchester, VA. Donation 5 Other (Specify) 22. Name and Address of Facility Huntt Funeral Rome 21. Signature of Funeral Service License 20601 3035 Old Washington Road Waldorf, MD. 12.12 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. VANCED. Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions. Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Exami that the death certificate be executed burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical P.O. Box 68760 the attending p IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown 4 Pregnant at time of death Month Dav Year ed by the at detached for Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 🗆 Yes 2 🗷 No Division of Vital Records, or Attending Physician: The law requires 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an page 2: has autopsy performe 1 🗆 Yes 2 🗙 No 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗆 Yes 잍 1 Nnpatient 2 🗆 ER/Outpatient 3 DOA funeral Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 Natural 2 Accident 5 Pending iours after death.

neral Director: Aft
filled in by the fur 1 🗌 Yes 2 🔲 No Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funeral L completely filled Medical certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Nedical Examiner: On the basis of exami (Check nation and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the bes of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day,

Registrar

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State

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	Physicia Media		Decedent's Name (First, Middle, Last) Frieda Turza					2. Date of De Month 03/06		Year	3. Time of Death 6:00A M
\bigcirc	Examir		4a. Facility Name (if not institution, give street a Rebecca House	nd number)		4b. City, Town, or Potomac	Location of Death			y of Death	
	Funeral Director		5. Social Security Number 063-03-3756 Usual Residence of Decedent	7. Age (In yrs. Ias	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Date 04/24)	y, Year)	Cour	place (State or Foreign htry) gary
	show d at	ē	10a. State 10b. County	10c. City,	Town or Loc	ation		3 .7			10d. Inside City Limits
	Maryl 28a-f otifie	Director	MD Montgomery	Bet	hesda						1 X Yes 2 □ No
	ith the 3a or the n	ra D	10e. Street and Number 5102 Cammack Drive			10f. Zip Code 20816			10g. Citizen of		,
	ems ar mus	Funeral	11. Marital Status 12. Wa	as Decedent Ever in U.S.	13. V	Vas Decedent of His	spanic Origin? (Spe	cify Yes or No-	United	State ce - Americ	
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Mar	shou and rism raum		19a. Informant's Name/Relationship (Type, Prin	t)		g Address (Street a					Code)
ď	and Heal		Peter H. Turza / Son 20a. Method of Disposition	20h Pla		Cammack I		hesda,			
Baltimore,	permit. Page 1 a Department of I Important: If ite any injury or of once.		1 ☑ Burial 2 ☐ Cremation 3 ☑ Remove 4 ☐ Donation 5 ☐ Other (Specify)	al from State cer	metery, crem	atory or other place	02/10		20c. Location Kew Gar	•	New York
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	certific rector,	8 B	25. Was case referred to medical examiner?				ce of Death (Check				. ()
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5	anding sath. or: Afte he fun	ficat	1 T Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	injury	work?	es 2 🗆 No	.ou. Describe II	ow injury occurr	au au	
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	To the Hospital of Within 24 hours aft To the Funeral Di Completely filled in	Medical	29a. Certifier (Check 2 Medical Examiner: On to only one) 3 Certifying Nurse Practi	he basis of examin <i>a</i> tion a	nd/or investic	ation, in my opinion	 death occurred at : 	the time date a	nd place and due	to the cau	sels) and manner stated
	2 × × × 2 × ×		29b. Signature and title of contifier	no, MC)	29c. License r D26571			29d. Date signed 03/06/2		Day, Year)
			30. Name and address of person who complete Irving Mizus MD 1060	Cause of death (Item 2: Concord S	3a) (Type, Pri t. Su		ensingto	n, MD 2	0895		
	State Registra		31. Date filed (Month, Day, Year) MAR 0 7 2012	32. Registrar's Signatur	park						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		For State Registrar	1100001	State of N	/laryland		ırtmen tificate			and M		giene Reg. No. 2	012	n	3031
Physicia Medic		1. Decedent's Name (First, Middle, Last) Gordon W. Thompson										ath Day	2012	3. Time o	of Death
Examin	er	4a. Facility Name (if not institution, give street and number) 1201 Dixona Drive					4b. City, Town, or Location of Death Edgewater				MAR	4c. Cou	County of Death Anne Arundel		
Funeral Director	Director	5. Social Security Number 256-74-8570 6. Sex 1. ★★ 2 □ F 65			st birthday) Yrs.	Months Days Hours M			24 Hrs. Min.	8. Date of Bird (Month, Da Aug. 1	y, Year)	9. Birthplace (State or Foreign Country) Hong Kong			
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any njury or other traumatic event, the Medical Examiner must be notified at once.		10a. State 10b. County 10c. City, Town or Lo					Edgewater							10d. Inside C	City Limits
		10e. Street and Number 1201 Dixona Drive					10f. Zip		037		:	-	Og. Citizen of What Country? U.S.A.		
	ed by Funeral	11. Marital Status 1 Never Married 3 Widowed 4	2 XX Married	2. Was Decedent Armed Forces 1 XX es 2 [If Yes, Give Year or Dates.	?		Vas Deced Yes, spec				cify Yes or No- Rican, etc.)	14. Spe	Race - Ameri Black, White, cify: Wh		
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nd 2 should be filed wealth and Mental Hygi n 27 is marked other er traumatic event,	To Be	17. Father's Name (Firs Gordon T							18. Mothe	er's Name	(First, Middle, ene Tit	Maiden Surn		oyeu	
		19a. Informant's Name Deborah T	PRelationship (Type)	Print) vife	_ 1						Route Numbe			Code) 21037	
Page 1 ar ment of He ant: If iten ury or oth		20a. Method of Disposi 1 Burial 2XX 4 Donation 5	Cremation 3 🗆 Re	moval from Stat	ce	ace of Dispos metery, crem Limore	atory or of	her place	y Y		o _{ate} /2012		on - City or T more,		and
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Medical Examiner		resulting in death)	tions a.	Due to (or a	s a conseque	ence of):									
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):													
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	To Be (25. Was case referred t examiner? 1 VYes 2 \(\subseteq \) N	Ho	spital:		-D/O +1'-		Other	ce of Deat	`					
		27. Manner of Death 1 A Natural 5 2 Accident	28c. Injury at work? M 1 🗆 Yes 2 🗆 No				ome 5 NResidence 6 □ Other (Specify) 28d. Describe how injury occurred								
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DHMH 17 Rev 06-2011

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

AMEND #26, PER VERBAL G932 10/26/12/TRT State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician/ :25 201 _D THEODORE Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Examiner EC PERRY A MARYLAND HEALTHCARE SYSTEM If Under 24 Hrs. 8. Date of Birth
Hours Min. (Month, Day, Year
AUGUST 29 9. Birthplace (State or Foreign If Under 1 Year 7. Age (in yrs. Funeral THEODORE Country Months 1 🔀 M 2 🗆 F 68 212-42-2322 1943 MARYLAND Director Usual Residence of Decedent 10d. Inside City Limits show 10b. County 10c. City. Town or Location 10a. State death with the Maryland Director permit. Page 1 and 2 should be filed within 72 hours after death with the Marylal Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f slamp injury or other traumatic event, the Medical Examiner must be notified: anno. 1 X Yes 2 No MARYLAND HARFORD ABERDEEN 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral UNITED STATES 606 SOUTH ROGER STREET 21001 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 12. Was Decedent Ever in U.S. 11. Marital Status Black, White, etc. Armed Forces?
1 X Yes 2 □ No GERALD þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: BLACK 1 ☐ Yes 2 No Specify: If Yes, Give 3 Widowed 4 X Divorced Year or Dates. 1962-68 Completed 16b. Kind of Business Industry 16a. Decedent's Usual Occupation 15 Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) DRIVER CAB SERVICE 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ JAMES TALLEY AUDREY WILLIS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 606 SOUTH ROGER STREET, ABERDEEN, MARYLAND 21001 GERALD K. TALLEY / SON 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 🗆 Burial 2 💢 Cremation 3 🗀 Removal from State ATLANTIC CREMATORY 3/8/12 4 ☐ Donation 5 ☐ Other (Specify) GLEN BURNIE, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility LISA SCOTT FUNERAL HOME, P.A. 552 LEWIS STREET, HAVRE DE GRACE, D-the MD 21078 Approximate Interval Between Onset and Death 23a. Part 1, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ ARCINOMA NON SMALL disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examine executed Cause (Disease or iinjury and I-tran that initiated events resulting in death) Last Due to (or as a consequence of) attending physician a for use as the burial-Physician/Medical certificate be Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy Month Day Year Hospital or Attending Physician: The law requires that the death in the past 12 months? Pregnant at time of death 2 No signed by the at a be detached for Yes 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 1 Yes 2 No 3 Probably 4 Unknown HYPERTENSION Completed peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an ASTHMA autopsy has performed? Yes 2 No death? 2 🗆 No 1 Yes 24 hours after death.

Funeral Director: After this certificate 26. Place of Death (Check only one) Division of Vital 25. Was case referred to medical funeral director, Be examiner?
1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 ื Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA 28c. Injury at work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28a. Date of injury Certificate: (Month, Day, Year) Natural Accident 5 Pending 1 Yes 2 No M Investigation completed filled in by the 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 Z Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F only one the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certification è 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1+1VM VA MARYLAND HEALTH CARE SYSTEM, PERRY FOINT, MD 32. Regist State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death Decedent's Name (First, Middle, Last Physician/ te Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner Ceci1 Port Deposit 443 Craigtown Road If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 8. Date of Birth Sex. . Age (In yrs. last birthday, . 1<u>961</u> **Funeral** (Month, Day, Hours Months Maryland 50 217-76-1016 Director Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location death with the Maryland Examiner must be notified at Director 1 Yes 2 No Port Deposit Maryland Ceci1 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 9 23a Funeral 21904 U.S.A. 443 Craigtown Road items ; Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) . Was Decedent Ever in U.S. Armed Forces? 14, Race - American Indian 11, Marital Status Black White etc. ò by 1 Never Married 2 Married 1 Yes 2 X No Baltimore, Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 X No Specify: Specify: White 'natural", 3 Widowed 4 Divorced Completed Year or Dates the Medical 16b. Kind of Business Industry 16a Decedent's Usual Occupation 15 Decedent's Education (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Ryder Leasing permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me College (1-4 or 5+) Elementary/Seconday (0-12) Elkton, Maryland Mechanic Eleven Years Be 18. Mother's Name (First, Middle, Maiden Surname) 17, Father's Name (First, Middle, Last) ဥ Etta Rolfe George Thompson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 443 Craigtown Road, Port Deposit, Maryland 21904 (father) George A. Thompson 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 X Burial 2 Cremation 3 Removal from State Hopewell Cemetery Port Deposit, Maryland 03/05/12 4 Donation 5 Other (Specify) 22. Name and Address of Facility Lee A. Patterson & Son Funeral Home, P.A. Perryville, Maryland 21903-0766 21. Signature of Funeral Service Licensee AULE 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) oran Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami executed Cause (Disease or iinjury that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician for use as the buria Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicis completed filled in by the funeral director, page 2 should be detached for use as the bur Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant □ Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Year Month Day Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 A No 2 X No 1 Tyes 25. Was case referred to medical 26. Place of Death (Check only one) Be 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) 1 Yes ည 4 Nursing Home 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Certificate: 1 Natural 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Dertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Light Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one)

State Registrar

Stephen Naylor, DO, 535 Rowlandsville Road, Conowingo, Maryland 31. Date filed (Month, Day, Year) MAR

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certi-

29c. License number

29d. Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001

Ame AAO	nd #26 r O Health	er Dep	ot. 3-7-12 KAH State of	f Maryland / Depa	artment of Health and N	Mental Hygier	
		_]	State Registrar	Cer	tificate of Death	Reg. I	No. 2012 09030
	Physicia Medic	n/	1. Decedent's Name (First, Middle, Last) Mary M. Werking				Day 12:45 P M
	Examin		a. Facility Name (if not institution, give street and num	ber)	4b. City, Town, or Location of Death		4c. County of Death
n and	31 13		615 McKin Way	7. Age (In yrs. last birthday)	Severna Park If Under 1 Year If Under 24 Hrs.	8. Date of Birth	Anne Arundel 9. Birthplace (State or Foreign
	Funeral Director		507-58-2549 1 □ M 2 🗓 K F	66 Yrs.	Months Days Hours Min.	(Month, Day, Yea.	r) Country)
	rland f show d at	tor	Usual Residence of Decedent 10a. State 10b. County Anne Arundel	10c. City, Town or Lo	cation rna Park		10d. Inside City Limits 1 ☐ Yes 2 ☒No
	he Mary or 28a-i notifie	Director	10e. Street and Number		10f. Zip Code	10g.	Citizen of What Country?
	with t	Funeral	615 McKin Way		21146		USA
တ	ould be filed within 72 hours after death with the Maryland of Mental Hygiene. marked other than "natural", or items 23a or 28a-f show marked other than "natural", or items 25a not 28a-f show matic event, the Medical Examiner must be notified at	by Fun	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes	rces? 2 XNo	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 X No Specify:	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
003	ours aft atural", sal Exa	eted	3 Widowed 4 □ Divorced If Yes, Given Year or Date of the Property of the Pr	ites.	dent's Usual Occupation	166	b. Kind of Business/Industry
21215-0036	in 72 h e. nan "na	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-	(Give life, D	kind of work done during most of worl O NOT use retired)	king	Home
2	iled within Hygiene. other thar ent, the N	L as I	12	HOITI	emaker	ne (First, Middle, Maid	
Maryland	uld be filed Mental Hyg arked oth atic event		17. Father's Name (First, Middle, Last) Matthew J. Reh	nan			
Man	2 should be Ith and Ment 27 is marker r traumatic e		19a. Informant's Name/Relationship (Type, Print) Pat Molesevich / Sister		ng Address (Street and Number or Ru McKin Way Severn		
Baltimore,	ige 1 and 2 should be f nt of Health and Menta t; If item 27 is marked / or other traumatic e		20a. Method of Disposition 1 □ Burial 2 X Cremation 3 □ Removal from	State 20b. Place of Disposer Commetery, cree	matory or other place) : Marc	n 06,	c. Location - City or Town, State
altim	permit. Page 1 Department of Important; If i any injury or once.		4 ☐ Donation 5 ☐ Other (Specify) 21. So nature of Anne I Server Licensee	1	- · · · · · · · · · · · · · · · · · · ·	2012	
m	a <u>n</u> e	377	23a, Pary 1. Enter the disease, or complications that of	agused the death. Do not ent	95 Ritchie Hwy,	Severr	na Park Funeral Home na Park, MD 21146
	Physician/	9	shock, or heart failure. List only one cause on ear Immediate Cause (Final disease or condition	ch line.	heart failure		Interval Between Onset and Death
Section of the Sectio	Medical Examiner		resulting in death) a. Due to	(or as consequence of):	heart failure try disease		
		iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	(or as a corresquence of):	austin		
	be executed sician and burial-transit	Examiner	that initiated events	(or as a consequence of):			
00	te be ex nysician he buria	ल	d				
6876	eath certificate be attending physic d for use as the b	n/Mec	IF FEMALE: 23c. If yes, our 23b. Was decedent pregnant	tcome of pregnancy			23d. Date of delivery
Box 68760	Attending Physician; The law requires that the death certificate be executed r death. ector. After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transi	Completed by Physician/Medic	in the months?	nant at time of death 5	☐ Ectopic pregnancy ☐ Other (specify)		Month Day Year
P.O.	requires that the dee been signed by the s should be detached	by Ph	Part II. Other significant conditions contributing to	death but not resulting in the	underlying cause given in Part I.		co use contribute to the cause of death? 2 No 3 Probably 4
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Division of Vital Records,	he law r te has t	dmo	peripheral vas mitral regurgita hyper cholester	olemia.		autopsy performe 1 \(\sum \) Yes 2	prior to completion of cause of death? No 1 Yes 2 No
al	stan; T	Be	25. Was case re. v.re to medical		26. Place of Death (Cris		has been been
of Vii	Physic r this or eral dire	 ₽	27. Manner of Death 28a, Date	Inpatient 2 ER/Outpatie	ent 3 DOA 4 Nursing lof 28c. Injury at	Home 5 Residence 28d. Describe how i	e 6 AOther (Specify)
ouo	ending sath. or; Afte	ficat	2 Accident Investigation	nth, Day, Year) injury	work? M 1 ☐ Yes 2 ☐ No		
ivisi	l or Att after de Directe d in by 1	Certi	4 Themiside determined 28e. Place	e of Injury - At home, farm, st ling, etc. (Specify)	treet, factory, office	28f. Location (Stree City or Town, S	et and Number or Rural Route Number, state)
L	To the Hospital or Attending Physician; The law within 24 hours after death. To the Funeral Director, After this certificate has completely filled in by the funeral director, page 2	Medical Certificate:	(O) I O BA - IV - I Francisco Ou the be	air of examination and/or inve	n occurred at the time, date and place, estigation, in my opinion, death occurred at the time, date and	l at the time, date and t	place, and que to the cause(s) and mainer states
	To the I within 2 To the I complete	ž	only one) 3 Certifying Nurse Practitione 29b. Signature and title of certifier	er: To the best of my knowledg	29c. License number		I. Date signed (Month, Day, Year)
0	->-0		1 Brooks mi	>	D40210		3-5-12
	1,		30. Name and address of person who completed cau	use of death (Item 23a) (Type, West Rive			
	St	ate		Registrar's Signature			
	Regist		MAR 0 7 2012	Enera S. L	back		

2-02009 dmiral Mansfield Wi		e Type or Print in Black I State of Maryland / Dep			gible.	2 0903
	- For State legistrar	Ce	ertificate of Death	Re	g. No.	
Physician/ ledical Examiner	1. Decedent's Name (Fir Admiral	st, Middle,Last) Mansfield	Wickes	2. Date of Deat Month March 9, 2		3. Time of Death 1919 hrs
3		institution, give street and number)	4b. City, Town, or Loc Chestertown	cation of Death	4c. County of Deat	h

Funeral Director Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other tranmatic event, the Medical Examiner must be notified at once. Physician

Exe	am and and all reassit and a reassit	
Division of Vital Records, P.O. Box 68760, To the Remind for Attending Physician The law remines that the death carifficults he assessed	within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit	
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	Registrar Certif	ricate oi	Death			F	Reg. No				
an/ ner	Decedent's Name (First, Middle, Last)				2	Date of De Month March 9,	ath Day	Year		3. Time of Death 1919 hrs	
1161	Admiral Mansfield W: 4a. Facility Name (if not institution, give street and number)	ickes	4b. City, Town,	or Location of		March 9,	2012	c. County of	Death	10101113	
	Chester River Hospital Center		Chesterto				- 1	Kent			
	5. Social Security Number 6. Sex 7. Age (In yrs. last	birthday)	If Under 1 Y						Faraian	place (State or	ī
	215-26-5509 1XM 2 F 81	Yrs		ays Hours	Min.	10/28	3/19	930	Cou	ntryMD	4
	Usual Residence of Decedent									464 1-14- 03- 11-3-	
	10a. State 10b. County 10c. City, To MD Kent Roc!	k Hal								10d. Inside City Limits 1 Yes 2 XNo	
to	10e. Street and Number		10f. Zip Code				10a Ci	izen of Wha	t Count		_
Director	5690 Edesville Road		2166				•	JSA	it Court	uy:	
	11. Marital Status 12. Was Decedent Ever in U.S.	13 Wa	s Decedent of I		gin? (Spec	ify Yes or N			Americ	an Indian, Black,	_
Jue	1 Never Married 2 Married Armed Forces?		es, specify Cub					White,	etc.	,	
y F	3 Widowed 4 Divorced If Yes (8ve Year 1951	1	Yes 2 X	lo specify:				Specify: a	СK		
Completed by Funeral			t's Usual Occup ost of working I				16b.	Kind of Busi	ness/In	dustry	
plet	Elementary/Secondary (0-12) College (1-4 or 5+)					,	Ι.				
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Be C	Clarence Mansfield Wich	koc			ace			Tilα	hma	n	
To	19a. Informant's Name/Relationship (Type, Print)		Address (Str	eet and Nun	nber or Rur						
	Belle J. Wickes/Wife		Edesv								
	20a. Method of Disposition 20b. Pla 1 Burial 2 Cremation 3 Removal from State	matory or oth	ition (Name of one place) nity A	M.C		Date /2012		Location - C	•		
	4 Donation 5 Other Specify:									·	
	21. Signature of Funeral Service Licensee	22. N	5 High	ess of Facility	Ben	nie S	Smit	h Fu	ner	al Home	
	23a. Part I. Enter the disease, or complications that caused the death. Do									Approximate Interva	ı
	failure. List only one cause on each line. Immediate Cause (Final disease a, Atherosclerotic Cardiovas	cular Dis	ease							Between Onset and Death	1
	or condition resulting in death) Due to (or as a consequence of):	704.4.7				- 7					_
L	Sequentially list conditions, b.								_		
nine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated										
Examiner	events resulting in death) Last Due to (or as a consequence of): d.										
Medical	UNPENDED AMENDED										
/Me	IF FEMALE: 23b. Was decedent pregnant in the	ncy					23	d. Date of d	,		
= 1	past 12 months? 1 Live birth Pregnant at time of death	, - =	tal dodtil	Ectopic	c pregnanc	У		Month	Da	ay Year	
ysic	1 Yes 2 No 9 Unknown g Unknown	5 Oti	her (Specify)								
Completed by Physicia	Part II. Other significant conditions contributing to death but not resu	ulting in the u	inderlying caus	e given in Pa	art I.					ne cause of death?	
d D						1 Ye	s 2	/ No 3	Proba	ably 4 Unknown	
plet						24a. Was auto	psy	pri	or to co	opsy findings available empletion of cause of	е
mo							ormed? 2 ✓ N		ath? Yes	2 No	
Be	25. Was case referred to medical examiner?			ce of Death	(Check onl	ly one)					
70	1 Yes 2 No No Inpatient 2 Y EF	R/Outpatient		Other ₄		Home 5		ence 6	Other:		
on	27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day, Year)	8b. Time of I		Yes 2		od. Describe	rnow inj	ury occurred	,		
icat	2 Accident Investigation 28e, Place of Injury - At home	e, farm, stree				Bf. Location	(Street a	and Number	or Rura	al Route Number, City	,
Certification:	3 Suicide 6 Could not be determined (Specify)					or Town,					
alC	29a. Certifier 1 Certifying Physician: To the best of my knowledge,										
Medical	one) 2 Medical Examiner:On the basis of examination and/ and manner stated.	or investigat			curred at th	he time, date					
ž	29b. Signature and title of certifier			nse number			191			th, Day, Year)	
			0.0	C.M.E.			Ma	rch 10, 20	U12		
	Name and address of person who completed cause of death (Item 23 Donna M. Vincenti, MD Assistant Medical Examir		W Baltimo	re Street	Baltimo	re MD 2	1223				
ate	·			5 50060,	Janano	, IVID Z					
ate trar	31. Date filed (Month Par Year) 2012 32. Registrar's Signature	7.									

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Physician/ 2:45 2012 Farrior Woodal1 March 4 Reuben Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Examiner** The Arbor at Baywoods Annapolis Anne Arundel 8. Date of Birth (Month, Day, Year, Nov. 9, 1 9. Birthplace (State or Foreign Social Security Number 420-52-7012 if Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** Days Months 90 **Director** 1 🛛 M 2 🗆 F 1921 Alabama Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medic I Examiner must be notified at Director Maryland Anne Arundel Annapolis 1 Yes 2 No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 7101 Bay Front Drive 21403 U.S.A. Funeral within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status rmed Forces?

Yes 2 \(\square\$ No þ 1 Never Married 2 XX Married Maryland 21215-0036 White 1 Yes 2XXNo Specify: If Yes, Give Year or Dates. 1943–69 Specify: 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. College (1-4 or 5+) **5+** Elementary/Secondary (0-12) Naval Officer U.S. Navy should be filed v and Mental Hyg is marked othe Be 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Reuben Russell Woodall Irene Bell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stephen R. Woodall/son 8180 Cottage Rose Ct. Fairfax Station, VA 22039 1 and 2 s f Health a item 27 i other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1 Department of Important: If it any injury or o 1 Burial 2 Tremation 3 Removal from State Baltimore Crematory | 3/7/2012 Baltimore, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition Ph_sician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any 1-ading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine attending physician and for use as the burial-transit the Hospital or Attending Physician; The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death 3 Ectopic pregnancy
Pregnant at time of death 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year signed by the atte Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown certificate has been si rector, page 2 should Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 Z 26. Place of Death (Check only one) 25. Was case referred to medical Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA After this within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 1 Secrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Solvens Island R.D. 139010 M 40 32. Registrar's Signature 06 2012 State Registrar

12-01832 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Robert Leroy Wright State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Robert Leroy Wright March 4, 2012 **Medical Examiner** 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City. Town or Location of Death Prince George's Prince George's Hospital Center Cheverly If Under 1 Year If Under 24Hrs 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs, last birthday) **Funeral** Director 03/08/1974 1 XM 2 F 577-82-4229 37 Yrs Usual Residence of Decedent in 10b. County 10c, City, Town or Location or 28a-f show Baltimore, MD 21215-0036
permit. Pages I and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23s or 28s-f show
injury or other traumatic event, the Medical Examiner must be notified at once. None Washington 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 20020 3431 Carpenter Street S.E. 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 X Never Married 2 Married 2 X No Yes $_{\text{Specify:}} \ \text{Black}$ If Yes, Give Yeer or Dates: 1 Yes 2 No specify: 4 Divorced Ճ 16a. Decedent's Usual Occupation (Give kind of work done 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Private Electrical Technician 12th 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Geraldine Burt Unknown 19a. Informant's Name/Relationship (Type, Print) Carpenter St., Geraldine Burt/Mother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 3/10/2012 Maryland National 4 Donation 5 Other Specify 21. Signature of Funeral Service License **Physician** /Medical a Multiple Sharp Force Injuries Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and Physician/Medical attending physician or use as the burial UNPENDED AMENDED IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Live birth Fetal death 3 Ectopic pregnancy past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown g Unknown the this certificate has been signed by the director, page 2 should be detached it Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Š Completed 24a. Was an autopsy performed? ✓ Yes 2 No 26.Place of Death (Check only one) 25. Was case referred to medical Be Hospital: 1 Inpatient 2 🗸 ER/Outpatient 3 DOA 1 🗸 Yes 27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? Mar 4, 2012 Subject stabbed 1018 hrs Natura 1 Yes 2 ✔ No Pending 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Could not be Suicide determined (Specify) Other (yard) 4 V Homicide

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) S.E. Washington, DC 20020 20c. Location - City or Town, State Laurel, MD 22. Name and Address of Facility Marshall-March Funeral Home 4308 Suitland Road Suitland, MD 20746 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Between Onset and Death Division of Vital Records, P.O. Box 68760, To the Hoppital or Attending Physiciae: The law requires that the death certificate be within 24 hours after death. 23d. Date of delivery Month Day Year 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 🗸 Yes Other Nursing Home 5 Residence 6 Other 28d. Describe how injury occurred To the Funeral Director: completely filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3607 Highwood Drive SE, Washington , DC 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and wife of certifi O.C.M.E. March 5, 2012 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner Victor Weedn MD JD 900 W. Baltimore Street, Baltimore, MD 21223 31 Date filed (Month, Day, Year) State Registrar OCME **ORIGINAL**

1101 hrs

Foreign Washington

10d. Inside City Limits 1 Yes 2 No

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	Cei	rtificate of D			g. No. 20	12 090	42
	Physicia		1. Decedent's Name (First, Middle, Last)	Helen Wade			2. Date of Death Month Februar		3. Time of Dea 2012 3:30	ath a ^M
	Medic Examin	_	4a. Facility Name (if not institution, give street as Southern Maryland Ho			Location of Death		4c. County of Death Prince Georges		
	Funeral Director		5. Social Security Number 6. Sex 172–24–3215 1 🗆 M 2	7. Age (In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) Aug. 14,1925 Pennsylvania			
	yland -f show ed at	ctor	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo					10d. Inside City Li 1 ☐ Yes 2 Ĵ	
	h the Mar a or 28a be notifi		Maryland Prince Geor	ges	Clinton 10f. Zip Code	20735	10	Og. Citizen of W		A 140
36	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by F	1 Never Married 2 Married 1	Vac 2 X No	Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 🛣 No	spanic Origin? (Spe n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race	- American Indian, k, White, etc.	
Maryland 21215-0036	72 hours a in "natural Medical Ex	Completed	15. Decedent's Education (Specify only highest grade com	oleted) (Give	dent's Usual Occup kind of work done o O NOT use retired)	ation during most of work	ing	16b. Kind of Bu		
1212	d within Hygiene. ther tha nt, the I	l as l	Elementary/Secondary (0-12) Twelve Years 17. Father's Name (First, Middle, Last)	lege (1-4 or 5+)	Cook	18. Mother's Nam	o (First Middle M		llege	
/lanc	d be filed Aental Hy Irked oth	To E	Joseph Moony				izabeth.			
Mary	2 should Ith and Me 27 is mark traumati		19a. Informant's Name/Relationship (Type, Prin James Wade (grand		ng Address (Street a			*	ate, Zip Code) sylvania 191	.50
Baltimore,	Page 1 and ment of Hea tant: If item iury or other		20a. Method of Disposition 1 【XBurial 2 ☐ Cremation 3 【X Remov 4 ☐ Donation 5 ☐ Other (Specify)	20b. Place of Dispo cemetery, crei		e)	Cate É		City or Town, State	
Balti	permit. Departr Imports any inju	ı	21. Signature of Funeral Service Licensee	m, 5°.	2. Name and Addres Lee A. Pa Perryvill	s of Facility tterson δ e. Marvla	Son Fur	neral Ho 03-0766	ome, P.A.	
	Ph_sician/ Medical Examiner as the prival-transit	al Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	oue to (or as a consequence of):					Approximate Interval Betwee Onset and Deat	
. Box 68760	requires that the death certificate be been signed by the attending physic should be detached for use as the b	Physician/Medical	in the past 12 months?	es, outcome of pregnancy Live Birth 2 Fetal death 3 [Pregnant at time of death 5 [Unknown	Ectopic pregnanc	cy		23d. Date	e of delivery nth Day Year	r
s, P.O.	res that the signed by dipe deta	b	Part II. Other significant conditions contributi	ng to death but not resulting in the	underlying cause giv	ven in Part I.			ibute to the cause of death	
3ecords	The law requi ate has been page 2 shoul	Completed					24a. Was ar autops perforn 1 \(\sum \text{Yes} \) 2	y p	Vere autopsy findings avai irior to completion of caus leath?	ilable se of
25. Was case referred to medical examiner? 1 Yes 2 No No No No No No No										1 1
Divisio	al or Attending I s after death. il Director: After ed in by the funer	Certificate:	2 \(\text{ Accident} \) 3 \(\text{ Suicide} \) 4 \(\text{ Homicide} \) 286	. Place of Injury - At home, farm, sti building, etc. (Specify)	reet, factory, office		28f. Location (Str City or Town,		er or Rural Route Number,	
	ne Hospital n 24 hours ne Funeral pletely filled	Medical	(Check 2 Medical Examiner: On	o the best of my knowledge, death the basis of examination and/or inves itioner: To the best of my knowledge	stigation, in my opinio	on, death occurred a	t the time, date and	d place, and due	to the cause(s) and manne	er stated.
	To the within 2 To the comple		29b. Signature and title of certifier		29c. License	e number	25	9d. Date signed	(Month, Dav, Year)	
	2		30. Name and address of person who complete Mic(I) AC(Sidanov		Print)	n RJ 6	+/01 FA	LARGA	8-12 for MD 20	,761
ľ	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Signature	a ded					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 20b per th g925 3-22-12 vt. State of Maryland / Department of Health and Mental Hygiene 20 | 2 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ H3th 26 2012 8:39 A Helen E. Wagner Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll Sykesville Transitions Healthcare If Under 1 Year If Under 24 Hrs. Date of Birth 9. Birthplace (State or Foreign Social Security Number **Funeral** 7. Age (In vrs. last birthday) Days Hours Min. Country) 10725/1927 Director 219-20-3495 84 1 □ M 2 🛛 F MD 28a-f show 10d. Inside City Limits 10b. County 10c. City, Town or Location Examiner must be notified at Director Yes 2 No MD Carroll Taneytown 10f. Zip Code 5 10e. Street and Number 10g. Citizen of What Country? Funeral "natural", or items 23a 21787 USA 41 Middle St. death \ Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 12. Was Decedent Ever in U.S. Armed Force Black, White, etc. 1 Yes 2X No If Yes, Give Year or Dates. 1 Never Married 2 Married à Baltimore, Maryland 21215-0036 filed within 72 hours after 1 Yes 2X No Specify. Specify: White 3 N Widowed 4 Divorced Completed other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) e 1 and 2 should be filed within 7, t of Health and Mental Hygiene. If item 27 is marked other than ' Elementary/Secondary (0-12) College (1-4 or 5+) waitress/cook restaurant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Larue Amold Fred Jenkins, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cindy Wagner, daughter John Hyde Road, Westminster, MD 21158
position (Name of Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Page 1 ò Important: I any injury o Carrollton Cemetery Finksburg, MD 3-20-12 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Linkse 22. Name and Projects as Funeral Home and Chapel, 412 Washington Road, Westminster, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury Die to for as a consequence of) Examir burial-trar that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical b Hospital or Attending Physician: The law requires that the death certificate be. 24 hours after death.
Property of the physician of the property o P.O. Box 68760 as the t IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent premant in the past 12 months?

1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ Month Year Pregnant at time of death signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 2 No 3 Probably 4 Unknown completely filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 Yes 2 No Yes 2 25. Was case referred to dical examiner? Be 26. Place of Dea heck only one) Hospital: ည 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 27. Manner 28b. Time of 28a. Date of injury (Month, Day, Year) 28c. Injury at 28d. Describe how injury occurred atural 5 Pending injury work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the I within 2 To the I only one 29b. Signature and title 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (item 23a) (Type, Print) mo Ernesto Mendoza M.D. Nashingt State

Registrar

Amend	ite	m n t	20b Please y Health Dept	Type or Pri mend #11 State of M	nt in BI Per FH arvland	ack In 6926 / Depa	delibl 4/16	e Ink	. Ensi l 2 Jh lealth a	ure Al	II Copie: ental Hy	s Are	e Legik	ole.	0.001.1
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	Funeral Director		5. Social Security Number 6. S		ge (In yrs. last		If Under Months		If Under Hours		8. Date of Bir (Month, Da 01/01/	th	9. Birthplace (State or Foreign Country) VERMONT		lace (State or Foreign
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land 21215-0036 be filed within 72 hours after death with the Maryland	"natural", or items 23a or 28a-f s edical Examiner must be notified	d by	1 ☐ Never Married 2 XX arried 9 XX widowed 4 ☐ Divorced	1 Yes 2 X If Yes, Give Year or Dates.	No No		☐ Yes 2						Specify:		
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			20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐	Removal from State	e cerr	ce of Dispos netery, crem KOAD	natory or o	ther plac	· .	MARCH 201	-			-	
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	cian ar ourial-t	_	resulting in death) Last	Due to (or as	a consequer	nce of):									
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K 68	attending physician and for use as the burial-transit	Physician/Medica	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome			Ectopic p	pregnanc	cy				23d. Date		*
Bo)	the att	ysici	in the past 12 months? 1 Yes 2 No 9 Unknown	4 🗌 Pregnant 9 🗍 Unknown		ath 5	Other (sp	pecify)					Mont	n	Day Year
P.O.	been signed by the s should be detached		Part II. Other significant conditions	contributing to death	but not result	ing in the u	nderlying	cause giv	ven in Part	1.					ne cause of death?
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Division of Vital Records, P.O. Box 68760 to the Hospital or Attending Physician: The law requires that the death certificate be	certificate has be lirector, page 2 sh	Completed by	(Julmorary)	Hypertle	CACON						24a. Was auto perf 1 \(\sum \) Yes	opsy ormed?	pri de	ior to co ath?	psy findings available mpletion of cause of 2 🔼 No
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ViSiO	within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral di	Certificate:	3 Suicide 6 Could not 4 Homicide determined	be 28e. Place of In	ijury - At hom tc. (Specify)	e, farm, str	eet, factory	y, office			28f. Location City or To			or Rura	Route Number,
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Tot	To th		29b. Signature and title of contifier	40			290	. Licens	e number	27-(29d. D	ate/signed	/_	31-
			30. Name and address of person who	completed cause of	death (Item ?	3a) (Tivne E	Print) 4		UY 5:	2/3		11	100	20	1 december 1
15			KHREN W. MEZ	NITT 69:	34 AV	IATIO	- Com	MI) }	017E	N-E	0	BURN	IE,	MD 2106/
	Sta Registr		31. Date filed (Month, Day, Year)	2012 32. Regist	trar's Signatur	A. A	back.	1						,	

Please Type or Printing Black Indelible Ink. Ensure All Copies Are Legible. amend #23a Per PHY 6/19/2012 III. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2012 Year Physician/ Day Elsie Gladys Zimmerman March 2 10:00 a M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 898 Nesbitt Road Colora Ceci1 8. Date of Birth Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🗓 F Hours Countre England Months October 1,1921 Director 216-18-0816 90 Usual Residence of Decedent 28a-f shov th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f shov traumatic event, <u>the Medical Examiner must be notified at</u> 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director 1 🗆 Yes 2 🔀 No Maryland Ceci1 Colora 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 898 Nesbitt Road 21917 U.S.A. filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give White 3 X Widowed 4 ☐ Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Personal Residence Twelve Years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic eve ည John Thomas Whittingham Gladys I. Dickens 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gail L. Shires (Daughter) 898 Nesbitt Road, Colora, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State cemetery, crematory or other place) 03/07/12 Baltimore, Maryland 4 Donation 5 Other (Specify) Woodlawn Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Lee A. Patterson & Son Funeral Home, P.A. Perryville, Maryland 21903-0766 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Pulmonary Fibrosis **Pulmonary** Interval Between LUNG Onset and Death Immediate Cause (Final Ph_sician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of). the burial-transit and Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 as IF FEMALE: use 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 X No
9 Unknown for Month Year Day ed by the a 9 Unknown is certificate has been signed by director, page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 X No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autonsv performed? Yes 2 A No After this certificate 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 2 🗓 No မ 1 Yes 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral to Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 XNatural 5 Pending iniury 2 Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 🛂 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Registrar DHMH 17 Rev 7/2009

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only one) 29b. Signature and title

31. Date filed (Month, Day, Year)

certifie

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AUGUSTINE HERMAN

32. Resistrar's Signature

MD

29d. Date signed (Month, Day, Year)

D0062190 SHAHNAWAZ KHAN

HWY, SUITEA, CHESAPENICE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Physician/ Arthur Edwin Armstrong 3:50 P M 2012 March Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Wilson Health Care Center Montgomery Gaithersburg Social Security Number If Under 1 Year If Under 24 Hrs 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** (Month, Day, Year Jan. 20, 1 Davs Hours 1 M M 2 □ F Director 277-07-8446 91 1921 Ohio Usual Residence of Decedent 28a-f show 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at. 10c. City, Town or Location 10d, Inside City Limits MD Montgomery Gaithersburg 1 X Yes 2 No Ö 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 20877 419 Russell Avenue #301 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Race - American Indian, Black, White, etc. Armed Forces?
1 ☑ Yes 2 ☐ No and 2 should be filed within 72 hours after of Health and Mental Hydiene by 1 Never Married 2 Married 21215-0036 Specify: White 1 ☐ Yes 2X No Specify: If Yes Give 3 🛮 Widowed 4 🗆 Divorced Year or Dates.1942-45 Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) d Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Banking Finance Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) and Mental F is marked o 2 Robert C. Armstrong Olive Nowell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9009 Holly Leaf Lane Bethesda, MD 20817 Arthur Edmond Armstrong/son 27 injury or other item 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Final Journey Crematory 3/22/12 Woodbine, MD Signature of Emeral Service License Going Home Cremation Service P.O. Box 784 M01651 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Years Immediate Cause (Final disease or condition Physician/ Dementia Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Exami Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and I for use as the burial-tran Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Month Day Year Yes 2 No 1 Yes 2 L 9 Unknown P.O. ģ signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed should 24b. Were autopsy findings available prior to completion of cause of death? has autopsy page 2 performe Yes 2 X No 1 ☐ Yes 2 ☐ No of Vital 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Other: 1 Yes 2 X No ပ္ 1 Inpatient 2 I ER/Outpatient 3 4 X Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: X Natural 5 Pending Division after death.

Director: Aff
d in by the fu 1 Yes 2 No ☐ Accident Investigation Suicide 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 24 hours a Funeral I Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the Hosp within 24 ho To the Fune completely f Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D20148 March 20, 2012 30+ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 911 Russell Avenue Gaithersburg, MD 20877 Steven Dolinsky 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 06-2011

Registrar

MAR 2 3 20

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 - State Registrar Certificate of Death 1, Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Steven Rick Anderson March 22, Da 2012 Year 2:50 A. M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Baltimore County Towson Gilchrist Hospice Center If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign Hours Months Aug. 09, 1961 235-11-7766 Buckhannon, W. VA 1 **X**M 2 □ F 50 Usual Residence of Decedent (Upshur County) 10d. Inside City Limits 10a. State 10c. City, Town or Location Director 1 🗆 Yes 2 🏞 No Cockeysville Maryland | Baltimore County 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? United States 21030 Funeral 8 C Warren Lodge Court Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian, 11 Marital Status Armed Force Black, White, etc. 1X Never Married 2 ☐ Married þ Yes 2 No 1 Yes 2 No Specify: White If Yes, Give Specify: Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) **02** Mens Grooming Barber Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Charlotte Grey Reger George Cecil Anderson 19a. Informant's Name/Relationship (Type, Print) (Mother) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lutherville, Maryland 21093 Charlotte Grey(nee Reger)Anderson 114 Westbury Road 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c, Location - City or Town, State (Harford County) Friday, (Harford County)
March 23,12 Forest Hill, Maryland Fuers Fireral Ordel and Cremation Services, Inc. 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee Jeffrey L.Gair, Sr. OFSP 2 Name and Althornatives Funeral and Cremation Center, P.A.

Lic. #M00677 2325 York Road Timonium, Maryland 21093-2215 23a. Part 1. Inter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, snock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final nonths resulting in death) Due to (or s a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a dunsequinal of): Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? 1 ☐ Yes 2 No

Physician/ Medical Examiner

Department of H Important: If ite any injury or oth

Funeral

Director

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er than "natural", or items 23a or the Medical Examiner must be

Page 1 and 2 should be filed within 72 hours after death iment of Health and Mental Hygiene.
Fant, If item 27 is marked other than "natural", or items ury or other traumatic event, the Medical Examiner mu

of Mental Hygiene.

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21215-0036

Baltimore, Maryland

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attending physician for use as the buria use as signed by the at the detached for signed by page 2 s funeral director. After this hours after death. filled in by the

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours a

To the Funeral C

completely filled

Medical

Accident
Suicide Investigation
6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 58303 Warch 22 2012

28c. Injury at work?

1 Yes 2 No

Other: 4 Nursing Home 5 Residence of Other (Specify) WOSOLL

28d. Describe how injury occurred

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Aman N. CLIANCES ST PONSON 6701

1 Inpatient 2 ER/Outpatient 3 DOA

28b. Time of

31. Date filed (Month, Day, Year)

27. Manner of Death

5 Pending

1 Natural 2 Accider

28a. Date of injury (Month, Day, Year)

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #23e Per PHY G926 4/202012 JH State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month2 Physician/ Shua 20 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** raisma 7. Age (In vrs. last birthday) 8. Date of Birth If Under 24 Hrs 9. Birthplace (State or Foreign **Funeral** Davs Hours Min **Director** 1**X** M 2 □ F 29. 21 Yrs Aug. 13, 1990 Maryland Usual Residence of Deced 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at Director 1 Yes 2 X No Maryland Harford Whitehall 10e, Street and Number ö 10f. Zip Code 10g. Citizen of What Country? Examiner must be Funeral items 23a 3107 Whitehall Road United States 21161 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2X No Black, White, etc. ò 1 X Never Married 2 Married à Maryland 21215-0036 If Yes, Give Year or Dates "natural", 1 Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Electrician Helper Stamper Electric Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Randolph Aversano Gwen Sanders traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau Randolph Aversano / Father 3107 Whitehall Road Whitehall, Maryland 21161 Baltimore, 20b. Place of Disposition (Name of 20a. Method of Disposition Mar. Date 20 20c. Location - City or Town, State Evans Funeral Chapel 1 Burial 2 Cremation 3 Removal from State 2012 4 ☐ Donation 5 ☐ Other (Specify) Forest Hill, Maryland 21. Signature f uneral Service 22. Name and Address of Facility
Evans Funeral Chapel & Cremation Service-BelAir
3 Newport Drive Forest Hill, Maryland 21050 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Closed Ph, sician/ nea disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner fellowwo Sequentially list conditions. Examine it any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) CEMPEICATION APPROVED BY MEDICAL EXAMINER -transit executed and that initiated events resulting in death) Last Due to (or as a consequence of) burialphysician s the burial Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 as 1 IF FEMALE: use 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy
5 Other (specify) ło in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death Day Year ed by the a detached f 9 🗌 Unknown g 🗌 Unknown P.O. s been signed by t 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23e. Did tobacco use contribute to the cause of death? by Records, 2XXNo 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page perform this certificate 2 No 1 🗌 Yes Yes 2 No Division of Vital director, 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner ? Hospital 2 🗌 No Other: မ 1 Inpatient 2 ER/Outpatient 4 Nursing Home 5 Residence 6 Other (Specify funeral 27. Manner of Death 28a. Date of injury (Month, Day, Certificate: 28h Time of 28c. Injury at 28d. Describe how injury occurred After ☐ Natural Accident 5 Pending death. ours after death eral Director: A filled in by the f 1 Yes 2 🔽 No 2012 Investigation Suicide 6 Could not be 28e. Race of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) To the Hospital within 24 hours a To the Funeral D Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only one Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 0138 30. Name and address of pe pleted cause of death (Item 23a) (Type, Print) MidwelA St Baltimore GREENE 31. Date filed (Month, Day, State Registrar's Signature Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Reg. No. 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) March 2012 ar Physician/ 18 11:45 A. Emily K. Boulais Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Howard Ellicott City Morningside House If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days January 30.1920 1 . M 2XX F Pennsylvania 164-16-5723 92 Yrs Director Usual Residence of Decedent 10d. Inside City Limits 28a-f shov 10a. State 10b. County 10c. City, Town or Location ral", or items 23a or 28a-f sho Examiner must be notified at filed within 72 hours after death with the Maryland Director 1 Yes 2 X No Ellicott City Maryland 1 4 1 Howard 10f, Zip Code 10a. Citizen of What Country? 10e. Street and Number Funeral U.S.A. 5330 Dorsey Hall Drive Apt#327 21042 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. 1 X Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No If Yes, Give Specify. White "natural", 3 Widowed 4 Divorced Year or Dates Page 1 and 2 should be filed within 72 hours ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natu ury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Bell Telephone Manager 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Anna McGuire Emile F. Boulais 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 10380 Derby Drive Laurel, Maryland 20723 (Niece) Stephanie Boccio 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of harmonic of harmonic line and injury or other any injury or other states. 1XX Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) SS.Peter and Paul Cemetery 3-21-2012 Springfield, Pennsylvania 22. Name and Address of Facility Witzke Funeral Homes, Inc. . Signatu e of Funeral Service Licenses MO1050 5555 Twin Knolls Road Columbia, Maryland 21045 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Annroximate 23a. Part 1 Interval Between Onset and Death Immediate Cause (Final Pancreatic Cancer Physician/ resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of or Attending Physician; The law requires that the death certificate be executed and the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last nding physician Physician/Medical Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy atter in the past 12 months?
1 ☐ Yes 2 ♣ No Month Year Dav for Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown is been signed by to should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2XX No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? page 2 s autopsy has performed? Yes 2 N 2 No 1 Yes certificate Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be Assisted examiner's Hospital Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{N Other} \) Other (Specify) Living 1 🗌 Yes 2 🗓 No ျာ 1 Inpatient 2 ER/Outpatient 3 DOA this funeral . Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: After iniury work? 1 X Natural 5 Pending n 24 hours after death.

e Funeral Director: Aft
bleted filled in by the fur 1 Yes 2 🗌 No Investigation Accident 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Hospital Medical 1 反 Certifying Physiefan: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Jurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2

To the I

complet 29b. Signature and title of cer 29d. Date signed (Month, Day, Year) 2017

Registrar
DHMH 17 Rev 7/2009

State

30

30. Name and address of per

31. Date filed (Month, Day, Year)

AndrewLazris, MD

MAR 23

Columbia, Maryland 21044

completed cause of death (Item 23a) (Type, Print)

6334 Cedar Lane #103

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1	For State of Mary State Registrar		tificate of Dea			eg. No. 2 ()	12	09050
А	Physicia		1. Decedent's Name (First, Middle, Last) Frank W. Beck				2. Date of Death Month March	Day 20	Year 12	3. Time of Death 4:25P M
Sing.	Medic Examin	al .	4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Loca	ation of Death		4c. County	of Death	
TO SE		88	Quail Run Assisted Li	ving yrs. last birthday)		y Hall Jnder 24 Hrs.	8. Date of Birth	Bal	9. Birthol	ace (State or Foreign
le.	Funeral Director		212-22-3067			ours Min.	(Month, Day, 1) Feb. 7, 1:		Penr	nsylvania
	nd show at	'n	Usual Residence of Decedent 10a. State 10b. County 10c	c. City, Town or Loc			100. 17		10	d. Inside City Limits
	Maryla 28a-f s otified	Director	MD Baltimore		Perry Ha	11 				1 ☐ Yes 2X No
	within 72 hours after death with the Maryland glene: et than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at the Medical Examiner must be notified at	eral D	10e. Street and Number 9900 Walther Blvd.		10f. Zip Code 21	234		0g. Citizen of W USA		ry?
	death v items	Funeral	11. Marital Status 12. Was Decedent Ever Armed Forces?	in U.S. 13. V	Vas Decedent of Hispan f Yes, specify Cuban, Me	nic Origin? (Sper exican, Puerto I	cify Yes or No- Rican, etc.)		e - America k, White, e	
036	rs after ral", or Exami	ed by	1 Never Married 2 Married 1 X Yes 2 No If Yes, Give Year or Dates.	1	Yes 2 XNo Sp	pecify:		Specify:	wh:	ite
215-0036	72 houl n "natu ledical	Completed	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business. (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business.							
212	within giene. ner thal t, the N		Elementary/Secondary (0-12) College (1-4 or 5+)		cklayer					
and	s should be filed within 7 h and Mental Hygiene. 7 is marked other than traumatic event, the M	To Be	17. Father's Name (First, Middle, Last) Frank William Beck		18.		e (First, Middle, M E. Boar)	
Maryland	should and Me is mar aumati		19a. Informant's Name/Relationship (Type, Print)	19b. Mailir	ng Address (Street and I	Number or Rura	l Route Number,	City or Town, S	tate, Zip C	ode)
e, ⊾	1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Health and Mental Hygiene. then Z is marked other than "hatural", or items 23a or 28a-f show item Z is marked other than "hatural" or items 2 hourst be notified at other traumatic event, the Medical Examiner must be notified at		Mary Seybold-sister 20a. Method of Disposition	Oh Place of Disno	Summit A		Date	20c. Location -	City or To	wn, State
Baltimore,	Page 1 ment of ant; If if ury or c		1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	cemetery cren Evans Fun and Crema	natory or other place) eral Chapel tion-Belair	l March	24,2012	Forest	Hi	ll, Maryland
Balt	permit. Page 1 and 2 st Department of Health a Important; If item 27 is any injury or other tra		21. Signature of Funeral Service Licensee	20	Name and Address of Vans Funera 800 Harford	Facility	el and C Parkvill	reamtio e,Maryl	n Ser	vices 21234
	- 1	Г	23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line.	death. Do not ente	er the mode of dying, su	uch as cardiac o	or respiratory arre			Approximate Interval Between Onset and Death
	y ician/ Medical		Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a co	S-7zc	e Dor	nent	ia			Onset and Death
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	sate be executed physician and the burial-transit	edical Examiner	that initiated events c. Due to (or as a co	nsequence of):						
092	physici the bu		d							
(68 ⁷	n certific ending r use as	an/M	IF FEMALE: 23c. If yes, outcome of g 23b. Was decedent pregnant 1 ☐ Live Birth 2 1	Fetal death 3	Ectopic pregnancy				te of delive	ery Day Year
Box	the att	ysici	in the past 12 months? 1 Yes 2 No 9 Unknown 1 Unknown	ne of death 5	Other (specify)			IVIC		Day Redi
P.O.	law requires that the death certificate be executed has been signed by the attending physician and a 2 should be detached for use as the burial-trans	Completed by Physician/M	Part II. Other significant conditions contributing to death but r	not resulting in the u	underlying cause given i	in Part I.				ne cause of death?
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of V	Attending Physician: ar death. ector, After this certific by the funeral director,	te: To	27. Manner of Death 28a. Date of injury	2 ER/Outpatie 28b. Time o ear) injury	f 28c. Injury at work?		28d. Describe ho	- ,		LIVIA
Division	ttendin death. stor: Aff y the fu	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be		M 1 ☐ Yes	3 2 □ No	28f. Location (Si	treet and Numb	er or Rura	Route Number,
Divis	tal or Ars after al Directed in by	l Cer	4 🗆 Homiciae determined building, etc. (\$	Specify)			City or Town			
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director, After this certificate has completely filled in by the funeral director, page 2	Medical	29a. Certifier (Check only one) Certifying Physician: To the best of my dedical Examiner: On the basis of examiner: On the	nination and/or inves	stigation in my opinion, o	death occurred a	it the time, date ar	nd place, and du	ie to the ca	use(s) and manner stated.
	To the within To the comple	Σ	only one) 3 L Certifying Nurse Practitioner: To the but 29b. Signature and title of certifier	est of my knowledge	29c. License nu			29d. Date signe		
	1/4	1	30. Name and address of person who completed cause of deat	7 h (Item 23a) (Tuna	Print)	6941		2/23/	12_	9 30
	V,		Saiome Hawkins Cole, DO,	FACP, 4	E. Rolling	Crissro	oads, Si	ute30	7, Ba	et more MD
	Sta Registi		30. Name and address of person who completed cause of deat Salome Hawkins Cos., Do, 31. Date filed (Month, Day, Year) 32. Registrar's	Signature	ared					

			Plea	se Type or Pri								_	jible.		
	-	For State		State of M	arylan		partment of e <i>rtificate of</i>			Mental Hy		00	110	0.0	0051
		Registrar 1. Decedent's Nam	ne (First, Middle	, Last)			er unicate or	Deati		2. Date of D	Reg. N eath	0. /		3 Time	of Death
Physicia Medic		WILLI	44	BEATTY :	JR.					Month 3	3 D.	ay 19	Year	12	084/M
Examine			f not institution,	give street and number)			4b. City, Town,				40	c. County	of Death		
Funeral		5. Social Security N	Moore I	6. Sex / 7. Ad	e (In vrs. I	ast birthday	BALT If Under 1 Yea		der 24 Hrs.	1 	irth		9 Rinth	nlace (Stat	e or Foreign
Director		215-76-8	8648	6. Sex 1 M 2 □ F	5	3 Yrs.	Months Day			(Month, D		8	Cour	itry)	Marylan
nd how	ř	Usual Residence of 10a. State	Decedent 10b. County		10c. Cit	y, Town or	Location				/ 1.35-41				City Limits
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ter des or ite miner	by Fi	 Marital Status Never Marr 	ried 2 Marr	Armed Forces?		5.	3. Was Decedent of If Yes, specify Cu	ban, Mexi	can, Puerto	Rican, etc.)	-		ck, White,		
iurs af tural", al Exa		3 Widowed		Year or Dates.			1 ☐ Yes 2 🔀 N		ify:		,	Specify	: WI	nite	
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permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	-	19a. Informant's Na				19b Ms	ailing Address (Stree							Cadal	
id 2 sh aalth au n 27 is er trau				(Spouse)			orth Kell								
t of He If iten or oth		20a. Method of Disp		3 ☐ Removal from State		Place of Dis	position (Name of rematory or other p	ace)	Morro	Date h 24,	20c. I	Location	- City or To	own, State	
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permil Depar Impor any in		21 Signature of Five	A	e 111			22. Name and Add	neral	Chapel	& Creme	tian	Servi	œs-B	al Air	
		23a. Part 1. Enteri	the disease, or	complications that caused inly one cause on each line	d the deat	h. Do not e	nter the mode of dy	ing, such	as cardiac	or respiratory a	arrest,	Arair		Approxin	
Physician/		Immediate Cause disease or condition	(Final	_ COLUN	(CANC	es.						10	Onset ar	
Medical Examiner		resulting in death)		Due to (or as	1 4										
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that th	by Ph	Part II. Other signi	ficant condition	ons contributing to death b	out not res	sulting in the	e underlying cause	given in Pa	art I.	23e. Did	tobacco	use cont	ribute to t	he cause o	of death?
quires en sign	ted b	DIABET	2-3							1 🗆	Yes 2	2 □ No	3 ☐ Pro	bably 4	Unknown
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To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the but	Medical	29a. Certifier	Certifying	Physician: To the best of	my know	ledge, deat	h occured at the tir	ne, date a	nd place, a	nd due to the c	ause(s) a	and mann	er as state	ed.	
the H thin 24 the Fu	Mec	only one) 3	3 L Certifying	xaminer: On the basis of e Nurse Practioner: To the	best of m	n and/or inv y knowledge	e, death occurred at	the time, o	ate and pla	at the time, date ice, and due to t	he cause	(s) and m	anner as s	tated.	manner stated.
5 N W Q		29b. Signature and	utie of certifier					rse numbe						Day, Year)	
Um		30. Name and addr	ress of person v	who completed cause of d	eath (Iten	1 23a) (Type		694	d		اد	141	20	12.	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Physician/ 2012 James Arthur Branch 03 :10P Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Holy Cross Silver Spring Montgomery 5. Social Security Number 7. Age (In yrs. last birthdav) If Under 1 Year | If Under 24 Hrs 8. Date of Birth 6. Sex 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Hours 237-36-1728 **Director** 1 € M 2 □ F 83 10/01/1928 N.C. Usual Residence of Decedent 28a-f show ms 23a or 28a-f shormust be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Washington 1 🗌 Yes 2 🙀 No D.C. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4306 12th Street Northeast 20017 USA items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14 Race - American Indian Hygiene. other than "natural", or iten ent, the Medical Examiner Black, White, etc. þ 1 Never Married 2 Married ☐ Yes Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: Specify:Black 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Blake Elementary/Secondary (0-12) College (1-4 or 5+) construction 8th Construction CO. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental I is marked o Jermit. Page 1 and 2 should be. Department of Heath and Mental Important: If item 27 is meany injury or othe-ပ John Branch Mamie Cooper 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William Branch/son 4306 12th Street NE., Wash., DC., 20017 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 11 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place) Harmony Memorial 3/20/12 Landover, MD Signature of Funeral Service Licensee 22. Name and Address of Facility 420 H St., NE. terrus + B.K. Henry Funeral Home 8 5110m Wash., DC. 20002 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Onset and Death Immediate Cause (Final Septic Shock Ph_irian/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Osteomyelitis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Peripheral vascular disease burial-transi Due to (or as a consequence of): attending physician for use as the buria Physician/Medical that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months? 1 Yes 2 No Month Day Year 5 Other (specify) Pregnant at time of death Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed has page 2 this certificate 1 ☐ Yes 2 ☐ No 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ည 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c, Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work? 2 🗀 No Accident Investigation Accider Suicide filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Registrar

State

29b. Signature and title of certifier

Khan

Nabila

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

3

1500

Forest

29d. Date signed (Month, Day, Year,

3/13/12

.s., Maryland

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Physician/ Month 03 Day 14 Edmita Bulota 2012 11:13 \mathbf{P} M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 1116 Skyway Drive Annapolis Anne Arundel If Under 24 Hrs 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2X□ F Months Days Hours Min. (Month, Pay, Year) 03/14/1955 Country) Lithuania Director 635-18-2676 57 Usual Residence of Decedent Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Mant if item 27 is marked of uther than "natural", or items 23a or 28a-f show luny or orther traunatic event, the Medical Examiner must be notified at. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1116 Skyway Drive 21409 **USA** Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2X No 14 Race - American Indian Black. White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 Yes 2 No Specify If Yes Give Specify 3 Widowed 4 Divorced Year or Dates White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Program Assistant 12 5+ Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Eduardas Maurukas Alicija 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr Peter Bulota / Husband 1116 Skyway Drive, Annapolis, MD 21409 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Chesapeake Crematory 3/15/2012 Beltsville, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility (Dorota Marshall Maryland Cremation Services, PO Box 1413Baltimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician CANCES IN v disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or illijury that initiated events attending physician and for use as the burial-tran the burial-trar Due to (or as a consequence of): resulting in death) Last Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) signed by the sign dispersed to the sign of the sign of the detached to the sign of the si Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed death? After this certificate 2 No Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other 1 Tes 2 No 은 4 Nursing Home 1 Inpatient 2 I ER/Outpatient 3 I DOA 5 Residence 6 Other (Specify) 27 Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural injury work? 5 Pending 2 🗌 No Accident
Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State Medical 29a Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one . Signature a 29d. Date signed (Month, Day, Year)

\OV State

Registrar

30. Name and addre

31. Date filed (Mor

0

Year,

Medici

who completed cause of death (Item 23a) (Type, Print)

egistrar's Signatur

P 1239

15/12

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ MARCH 19.2012 10:03P VERNON T. BARTHOLOW Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTO. DUNDALK HERITAGE CENTER 5. Social Security Number 6. Sex 1 M 2 G F 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) Funeral Months Days Hours JUNE th, P7, 1927 MARYZAND 84 Vrs Director 217-20-5792 Usual Residence of Deceden or 28a-f show 10a, State 10b. County within 72 hours after death with the Maryland 10c. City, Town or Location 10d, Inside City Limits Examiner must be notified at **Funeral Director** 1 Yes 2 X No MD BALTO. SPARROWS POINT 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code items 23a 21219 IISA 8501 NORTH POINT ROAD 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black, White, etc. ò þ 1 Never Married 2 Married X1950-1952 Maryland 21215-0036 1 ☐ Yes 2 ₩ No Specify: "natural", Completed Specify. WHITE 3 X Widowed 4 Divorced Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 랿 BETHLEHEM STEEL CO. CRANE & TRACTOR OPERATOR 12TH Be permit. Page 1 and 2 should be filed. Department of Health and Mental Himportant: If item 27 is more any injury or other. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 ANNA YOUNG ALBERT BARTHOLOW 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 569 POINTE OF OAKS ROAD SUMMERVILLE, SC. 29485 DAVID BURKMAN SON 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) 3-22-2012 MIDDLE RIVER, MD. HILLS MEM. 22. Name and Address of Facility CHARLES S. Signature of Funeral Service Licensee ZEILER & SON INC. **EASTERN AVENUE** BALTO. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Physician/ disease or condition Medical resulting in death) nce of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of) attending physician and for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year 5 Other (specify) Pregnant at time of death signed by the significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Be Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform this certificate 1 Yes 2 No 25. Was case referred t funeral director, Place of Death (Check only one, examiner? 2 No Other: 1 Tes မ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Mann of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred After **Natural** 5 Pending Accident
Suicide 2 🗆 No 1 Yes Investigation within 24 hours after deat To the Funeral Director: Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 | 3 |

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State Registrar

31. Date filed (Month, Day, Year)

only one 29b. Signature and title of

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th (Item 23a) Type, Print)

29c. Lic

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 9:20PM 2012 Warren Harmon Beardsley Sr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Harford Upper Chesapeake Medical Center Bel Air If Under 24 Hrs. Birthplace (State or Foreign Country) Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days Hours Mir (Month, Day, Year) **Director** 006-24-6475 1**X** M 2 □ F 83 June 25, 1928 Maine Usual Residence of Decedent ms 23a or 28a-f sho must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland | Harford Kingsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2504 Loloa Drive 21087 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 14. Race - American Indian, 11. Marital Status Black, White, etc. Completed by 1 Never Married 2 XMarried 1 Yes 2 No Specify Specify. "natural", 3 Widowed 4 Divorced White Year or Dates Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) nd Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4 or 5+) the Technician Communications other traumatic event. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental မ Page 1 and 2 should be Conrad Teneck Beardsley Marquerite Susan Larrabbee 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) t of Health Kathryn Walsh Beardsley / Spouse 2504 Loloa Drive, Kingsville, MD 21087 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State ò Department or Important: If any injury or once. Mays Chapel U.M.C. Cem. 4 ☐ Donation 5 ☐ Other (Specify) 3-22-2012 Timonium, Maryland permit. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ Neuron disease or condition resulting in death) day Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury UNKNOWN executed and that initiated events Due to (or as a consequence of resulting in death) Last the attending physician Physician/Medical pe that the death certificate IF FEMALE esn 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year 2 No 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown Records, 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autop performed death? 2 No Physician: Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred I or Attending P s after death. I Director: After 1 Natural 5 Pending injury work' 1 Yes 2 No the Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital within 24 hours a To the Funeral D Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) March 19, 2012 10053568 10/20 500 UP sapeake 30. Name and address of no completed cause of death (Item 23a) (Type, Print) Leffrer NOMPSON land 32 Registrar's Signature State

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Registrar

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Theresa Bittle	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Physician/ dical Examine	State of Maryland / Department of Health and Mental Hygiene 1- For State State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2012 0905									
		egistrar . Decedent's Name (First, Middle,Last)		Date of Death Month Da		3. Time of Death				
		Theresa Platania Bittle		March 19, 20	12	0804 hrs				
		a. Facility Name (if not institution, give street and number) 4b. (City, Town, or Location of Death		4c. County of Death					
		Opper Chesapeake Medical Server	Bel Air	1500	Harford	chalosa (State or Foreign				
Funeral Director	- 1	, Social Security Number 6. Cox	If Under 1 Year If Under 24Hrs. Months Days Hours Min.		Col	thplace (State or Foreign untry) t., MD				
	h	Jsual Residence of Decedent				10d. Inside City Limits				
'any	Γ	0a. State 10b. County 10c. City, Town or Location				1 Yes 2 X No				
Maryland 28a-f show any d at once.	5	MD Harford Fallston		1400	Citizen of What Cour					
ith the Maryland 23a or 28a-f sho notified at once.		0e. Street and Number	0f. Zip Code			id y r				
tified r		1709 Arabian Way	21047		SA	Latina Block				
with ms 23	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was D 14. Married 15. Armed Forces? 15. Married 1	Decedent of Hispanic Origin? (Sp specify Cuban, Mexican, Puerto	pecify Yes or No- Rican, etc.)	14. Race - Ameri White, etc.	ican Indian, Black,				
death ir iter	Canaity T.Th	4 = 0								
after all, o	ᆰ	or Dates:	es 2 X No specify:	vedi dece 116	Specify: Wh b. Kind of Business/	ite				
ours xam		during most	Usual Occupation (Give kind of v of working life, DO NOT use reti		b. King of Edsiressi	madony				
6 72 h		Elementary/Secondary (0-12) College (1-4 or 5+)			Own Home					
withir ene.		12 Homemak	18 Mother's Name	e (First, Middle, Maio		·				
21215-0036 Juld be filed within 7 Mental Hygiene. marked other than ic event, the Medical		17. Father's Name (First, Middle, Last)		n S. Sagn						
d be fental sarke event	8	Joseph V. Platania 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing A	ddress (Street and Number or	Rural Route Numbe	r, City or Town, State	e, Zip Code)				
shoul and N is m	٩	100. 1110111111111111111111111111111111	Arabian Way, Fa							
MD and 2 sho salth and em 27 is em 27 is raumati	-	20a Method of Disposition 20b. Place of Disposition	on (Name of cemetery,	Date 2	Oc. Location - City or	Town, State				
of He		1 Burial 2 Cremation 3 Removal from State crematory or other		/22/12	Glen Burn	of a MD				
Pag ment tant:		4 ponation 5 Other Specify: Atlantic C	me and Address of Facility Sc							
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once the proof of the pro) W. MacPhail R							
		the death Denet orter the	mode of dving, such as cardiac (or respiratory arrest.	shock, or heart	Approximate Interval				
Physician Medical	1	233/ Part I. Enter the disease, or complications that caused the death. But it enter the failure. List only one cause on each line. Alcohol and Mixed Quetiapine) Intoxi	Drug (Citalop	ram, Zolp	idem,	Between Onset and Death				
Examiner	- 1		cation			 				
, ke,		or condition resulting in death) Due to (or as a consequence of):								
	ᡖ	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):								
	튑	cause. Enter Underlying Cause								
isi d	Examiner	events resulting in death) Last Due to (or as a consequence of):								
be executed sician and urial - transit	dical	MENDED 23a,27,28a-f pe	er me 0925 3-27	′-12 vt						
O, be esticiar	ğ				23d. Date of delive	ny				
Box 68760 e death certificate the attending physical for use as the bu	sician/Me	IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnancy 1 Live birth 2 Feta	Il death 3 Ectopic pregn	nancy	Month	Day Year				
certi	cia		er (Specify)							
Box death he atte d for u	ıysi	1 Yes 2 No 9 V Unknown 9 Unknown		Too. Bidash	and the sentitude to	o the cause of death?				
ਦੇ ਵ	y Phy	Part II. Other significant conditions contributing to death but not resulting in the un	iderlying cause given in Part I.			obably 4 V Unknown				
P.O.	d by					autopsy findings available				
rds requi	ete			24a. Was an autopsy	prior to	completion of cause of				
e law e has	Completed			perform 1 ✓ Yes 2						
Division of Vital Records, P.O. Box 68760 epital or Attending Physician: The law requires that the death certificate bours after death. Per Application: After this certificate has been signed by the attending physician by the funeral director, page 2 should be detached for use as the business.		25. Was case referred to medical	26. Place of Death (Chec	k only one)						
rita siciar is cer	Be	examiner? Hospital: 1 Innation 2 FR/Outpatient	3 DOA Other Nurs	sing Home 5 R	esidence 6 Oth	ner:				
of Viting Physic	5	1 ✓ Yes 2 No "Injection 2 2 Use an arrangement of Line of Injury 28b. Time of Injury	jury 28c. Injury at Work?	28d. Describe ho	w injury occurred					
ding h. Aft	ion	1 Natural 5 Pending (Month, Day, Year)	1 Yes 2 No	unknow	n					
Division tall or Attendin rs after death.	Certification:	2 Accident Investigation Fd 3-19-12 Fd 7:06a 28e. Place of Injury - At home, farm, street	t, factory, office building, etc.	28f. Location (St	reet and Number or I	Rural Route Number, City				
Divi	ıţ	Suicide Could not be determined (Specify)		or Town, Sta	abian Way	, Fallston,				
ospita hour unera ly fill		29a Certifier . The second section of multipowledge death occurry	red at the time, date and place, a	nd due to the cause	(s) and manner as st	tated.				
Division of Vital Records, P.C To the Hospital or Attending Physician: The law requires that within 24 hours after death. To the Funeral Director: After this certificate has been signed to completely filled in by the funeral director, page 2 should be detained.	Sa	one) 2 Medical Examiner: On the basis of examination and/or investigation	on, in my opinion, death occurred	d at the time, date a	nd place, and due to	the cause(s)				
	Medical	and manner stated. 29b. Signature and title of certifier	29c. License number		29d. Date signed (M	Month, Day, Year)				
To t With To t	-	0, 10 /0100	O.C.M.E.		March 19, 2012	2				
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To t with To t To t		30. Name and address of person who completed cause of death (Item 23a)	imore Street. Baltimore.	MD 21223						
		Carol Allan, MD Assistant Medical Examiner 900 W. Balti	imore Street, Baltimore,	MD 21223						
	tate	Carol Allan, MD Assistant Medical Examiner 900 W. Balti 31. Date filed (Month Day, Year) 32. Registrar's Signature		MD 21223						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. nd #2 per PHY G930 8/15/2012 JH State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ ^{ay}2012 BALDWIN MARCH 18 RUBY 6:12 P Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** PRINCE GEORGE'S 9700 LAKE POINTE # 204 UPPER MARLBORO CT. If Under 1 Year If Under 24 Hrs. g. Birthplace (State or Foreign cial Security Number 7. Age (In vrs. last birthday 8. Date of Birth **Funeral** SEPT. 18 579-62-0479 Days Hours NORTH CAROLINA Director 1943 1 M 2 X F 68 Yrs Usual Residence of Decedent 28a-f show 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits with the Maryland must be notified at Director 1 Yes 2 No PRINCE GEORGE'S UPPER MARLBORO MD ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 9700 LAKE POINTE # 20774 USA CT. Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. ıral", or iten Examiner Armed Forces Black White etc þ 1 Never Married 2 Married Yes 2 X No BLACK Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify 3 Widowed 4 X Divorced Completed of Health and Mental Hygiene. item 27 is marked other than "natur other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) 2YRS Elementary/Secondary (0-12) GOVERNMENT EXECUTIVE ASSISTANT Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ ETHEL ROBINSON LESTER STURDIVANT 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20774 600 MT. LUBENTIA COURT UPPER MARLBORO, MARYLAND KIM WOODS/DGT Department of Healt Important: If item 2 any injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 3/27/2012 WALDORF, MARYLAND HERITAGE CEMETERY 4 Donation 5 Other (Specify) 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME, INC. Signature of Funeral Service Licensee reens 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 23a. Part 1. Injer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, by heart failure. List only one cause on each line.

Immediate Cause (Final Approximate Interval Between Onset and Death Physician/ disease or condition resulting in death) MALIGNANT NEOFLASM Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause (Disease or injury Examine - Due to (or as a consequence of) as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 🛣 No
9 ☐ Unknown Month Year Other (specify) Pregnant at time of death been signed by the s should be detached q 🖂 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 Yes 2 No 3 Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy performed?

1 Yes 2 X No cate has i certificate funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 T Residence 6 Other (Specify) 2 🔀 No Medical Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 24 hours after death.
Funeral Director: After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at injury 1 X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2. only one) 29d. Date signed (Month, Day, Year) 29b. Signatur Name and address of person who completed cause of death (Item 23a) (Type, Print) Ct. Ste 200 Largo MD 20774 Basil elanie Reynold State 2012 3 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ . 2012 Year March 20, James Clair Bowman Jr. 8:45 n Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Oak Crest - Renaissance Gardens Parkville Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 143-16-3411 Director 1 **X** M 2 □ F 91 Jan.4,1921 Usual Residence of Deceden New York 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits at Director must be notified 28a-f MD 1 🗆 Yes 2 😾 No Baltimore Parkville 10f. Zip Code ō 10e. Street and Number 10a, Citizen of What Country? 23a Funeral 8820 Walther Boulevard, Apt-4222 21234 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ▼Yes 2 → No
If Yes, Give 1943-1946 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black, White, etc. or þ 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: 'natural", Specify: white 3 Widowed 4 Divorced Completed Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry than, Elementary/Secondary (0-12) College (1-4 or 5+) the Union Carbide 5+ Sales traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) and Mental | is marked c 2 James Clair Bowman Reva Maud Lownsberry 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other traunonce. Patricia L. Erdman/daughter 1022 Kenilworth Drive Towson, MD. 21204 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 3/21/2012 Baltimore, Maryland Metro Crematory Inc. 21. Signature of Funeral Service Licensee Stephanie Custer 22. Name and Address of Facility Cremation Society of MD.Inc. 299 Frederick Road Baltimore, MD. 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Onset and Death Physician/ ASCVI disease or condition resulting in death) Medical Due to (or as a consequence **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical the as IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Veal 5 Other (specify) signed by the at Id be detached for Pregnant at time of death 1 Yes 2 9 Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an page 2 s autopsy perform Yes Division of Vital funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: ဂ္ 1 Inpatient 2 I ER/Outpatient 3 I DOA 4. Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 24 hours after death. Funeral Di ector: Afte 1. Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 only one 3. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier ause of death (Item 23a) (Type, Print) 121 Parkville

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Reg. No. 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 20^{Day} Physician/ March BOYCOTT ROSE 20°12 \mathbf{p}_{M} 9:07 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Baltimore 2115 Lodge Farm Road Sparrows Point . Social Security Number If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Days Hours 212-20-2642 **Director** 1 M 2 XF 86 June 21, 1925 Maryland | Usual Residence of Decedent items 23a or 28a-f show ier must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Sparrows Point 1 Yes 2 X No Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21219 2115 Lodge Farm Road United States death v 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married "natural", or Completed by 1 Yes 2 If Yes, Give Year or Dates. 2 🖂 No Baltimore, Maryland 21215-0036 within 72 hours after 1 Yes 2 No Specify. White 3 Widowed 4 Divorced Specify: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Ith and Mental Hygiene.
27 is marked other than r traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) Home Maker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Margaret Gilmore Walter Keichenmeister Department of Health and Important: If item 27 is m any injury or other traums 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2115 Lodge Farm Rd., Sparrows Point, MD 21219 C. Dudley Boycott / Husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. | 03/22/2012 | Baltimore, Maryland 22. Name and Address of Facility Cremation Society of Marylan Inc 21. Signature of Funeral Service Licensee Alyson K Taylor 299 Frederick Road, Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) NONSMALL CELL LUNG CANCER Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner if any leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and tran that initiated events resulting in death) Last Due to (or as a consequence of) burial-Physician/Medical Division of Vital Records, P.O. Box 68760 the IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Year Pregnant at time of death Day Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 X Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No page 2 🗌 No 1 Yes the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital 1 Yes 2 No Other: ပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🗷 Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending injury 1 Yes 2 No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of ce -MD DOO61635 MARCH 22, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 101 JHBMC 301 Mason Lord Drive, 1st Floor Baltimore, MD Jessica Colbum, MD 21224 31. Date filed (Month, Day, Year) **

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ HOWARD BLUMBERG MARCH 20. 2012 1:58 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death STELLA MARIS HOSPICE TIMONIUM BALTIMORE 5. Social Security Number 7. Age (In vrs. last birthday 1 Year If Under 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 216-12-9143 Director 1 XM 2 □ F Yrs 87 05/14/1924 MD ms 23a or 28a-f show must be notified at 10b, County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD 1 Yes 2 No BALTIMORE OWINGS MILLS 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9766 ASHLYN CIRCLE 21117 USA items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. Examiner Armed Forces
1 X Yes 2 If Yes, Give þ "natural", or 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: 3 ☐ Widowed 4 ☐ Divorced Completed Year or Dates WHITE permit. Page 1 and 2 should be filed within 72 hour.
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) 12 SALES MENS CLOTHING Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ BLUMBERG ROSE STALMAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20. CHERIE TUIL/DAUGHTER 9766 ASHLYN CIRCLE, OWINGS MILLS, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Donation 5 Other (Specify OHEB SHALOM MEM PARK 03/22/2012 REISTERSTOWN, MD of Funeral Service Lites 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, 23a. Part 1. Enter the disease, or compilications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) CONGESTIVE HEART FAILURE Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of). tran and that initiated events resulting in death) Last Due to (or as a consequence of): burial-Physician/Medical Records, P.O. Box 68760 BLUMBERG the as IF FEMALE: nse 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? Month Day 5 Other (specify) Year 2 🗆 No 9 Unknown signed by the HOWARD Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has pa e 2 autopsy certificate 1 ☐ Yes 2 ☐ No Division of Vital To the Hospital or Attending Physician; director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 Yes 2 X No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 X Other (Specify) HOSPICE this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending X Natural injury s after death.

I Director; Af 1 ☐ Yes 2 ☐ No Accident Investigation the Suicide 6 Could not be ò Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide

within 24 hours a

Ou,

State

Registrar

Medical

29a Certifier

(Check

29b. Signature and title of certifi

MORGAN

CRNP

TRACIE L.

se of death (Item 23a) (Type, Print)

2300 DULANE

City or Town, State)

TIMONIUM, MD 21093

29d. Date signed (Month.

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 🗶 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

VALLEY RD.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		-	For State Registrar	State of Ma	ryland	-	irtment of H <i>tificate of D</i>		d Mental Hy	giene Reg. No.	2012	09061
1. Decedent's Name (First, Middle, Last) 2. Date of Month									2. Date of De		Year	3. Time of Death
1	Medic	al	April Marie Bi						March	16	2012	19:00 PM
	Examin	ŭ.		HOD Pita	1		7	ama	he		ounty of Death	
	Funeral Director	- 1	5. Social Security Number 6. Security Number 6. Security Number 1		(In yrs. las	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hours N	Hrs. 8. Date of Bir Min. Month, Da 04/2,2/	1963	g. Birth Cour Mar	place (State or Foreign oftn) yland
	and show lat	ō	Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Loc	ation					10d. Inside City Limits
	Maryl 28a-f otified	irect	Maryland Baltimor	re	Cat	onsvi]						1 ☐ Yes 2 🂢 No
	ith the	Funeral Director	10e. Street and Number 216 Paradise Aver	110			10f. Zip Code 21228			_	en of What Cou ced Stat	
	eath w	-une	11. Marital Status	12. Was Decedent Ev	er in U.S.	13. V	Vas Decedent of His	spanic Origin	(Specify Yes or No-		I. Race - Americ	can Indian,
960	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	1 Never Married 2 Married 3 Widowed 4 X Divorced	Armed Forces? 1 ☐ Yes 2 ☒ N If Yes, Give Year or Dates.	lo		Yes, specify Cubar ☐ Yes 2 🛛 No		uerto Rican, etc.)	Sp	Black, White, pecify: Wh:	
15-0	72 hou r "natu ledical	Completed	15. Decedent's E (Specify only highest gra	ade completed)	_ 1	(Give I	ent's Usual Occupa ind of work done do NOT use retired)	ition uring most of	working	16b. Kind	of Business In	ndustry
212	within giene. er thai		Elementary/Seconday (0-12)	College (1-4 or 5+	-)		stress			Sai	iling	
and	oe filed ental Hy ked oth c event	To Be	17. Father's Name (First, Middle, Last) Horvall H. Bishor)			:		Name (First, Middle, euline M.			
aryl	hould I and Me s marl umati		19a. Informant's Name/Relationship (7)					nd Number o	r Rural Route Numbe	r, City or To	own, State, Zip	
Σ	nd 2 si lealth a m 27 i		Johanna Plaisance	- Sister	T			Drive (Clayton, N			
Baltimore, Maryland 21215-0036	Page 1 a nent of H int: If ite iry or otl		20a. Method of Disposition 1 ☐ Burial 2 🌠 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif	Removal from State	ce	metery, cren	sition (Name of natory or other place Cremator		Date /17/2012		ation - City or T Burnie	, Maryland
Balti	permit. Departn Importa any inju	9	21. Signature of Funera Service Licen	<u></u> ее		D2	Name and Address Wild J. Wild St. Will St. Wild St. Wild St. Wild St. Wild St. Wild St. Wild St. Will St. Wild St. Will	eber F dson A	uneral Hor venue Balt	nes P.	A. Mary	land 21229
			23a. Par 1. Enter the disease, or comeshook, or heart failure. List	plications that caused the cause on each line.	the death							Approximate Interval Between
	Pnysician/	1	Immediate Cause (Final Isease or condition	Advan	لع	liver	_ direa	se fu	on alcoh	olic		Onset and Death
	Medical Examiner		resulting in death)	Due to (or as a	conseque	ence of):		7	Circho	nis		Days
		iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a	nui sedili	mosicly.						
	ecuted and transi	Examiner	Cause (Disease or linjury that initiated events resulting in death) Last	c. Due to (or as a	conseque	ence of):						
09,	ate be executed physician and the burial-transit	edical I		d								
3876	rtificati ling ph e as th	/Mec	IF FEMALE:	23c. If yes, outcome o	f prognar	nov.						
P.O. Box 687	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	1 Live Birth 2 4 Pregnant at 9 Unknown	2 🗀 Fetal	death 3	Ectopic pregnanc Other (specify)	У		23	Month	Day Year
	requires that the de been signed by the should be detached	ρ	Part II. Other significant conditions of	ontributing to death bu	t not resu	ulting in the u	nderlying cause giv	en in Part I.				the cause of death?
$B_1 S H OP_A P R R$	has been ge 2 shoul	Completed							24a. Was auto perfe	psy ormed?	prior to co death?	opsy findings available ompletion of cause of
~_ <u>~</u>	sician: The law i certificate has b irector, page 2 s	Be Co	25. Was case referred to medical				26. Pla	ace of Death (1 🗌 Yes Check only one)	2 🗶 No	1 🗌 Yes	2 No
$SHOP_{o}$	hysicia his cer Il direct	70 B	examiner? 1 Yes 2 No				nt 3 🗆 DOA Othe	4 ∐ Nursi	ng Home 5 Resi			5y).
iSt in of	ding P th. After th funera	cate:	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	28a. Date of injury (Month, Day,	Year)	28b. Time of injury	work		28d. Describe	now injury o	ccurred	
B ivisio	Section Street and Number or Notice Section Street and Number or Notice Section Street and Number or Notice Section Section Street and Number or Notice Section Sect									Number or Rura	al Route Number,	
۵	Hospital 4 hours : Funeral I ted filled	Medical	(Check 2 Medical Exam	sician: To the best of r iner: On the basis of ex	amination	and/or invest	tigation, in my opinio	n, death occu	rred at the time, date	and place, a	nd due to the ca	ause(s) and manner stated.
	o the l	Me	only one) 3 Certifying Nur 29b. Signature and title of certifier	se Practioner. To the b	est of my	knowledge,	death occurred at the 29c. License		d place, and due to th		and manner as s signed (Month,	
	->-0		M. Pron	7	1.1)		1 '					,2012
_	101		30. Name and address of person who	rantrale	2,	900	S. Cat	A no	ve Balt	romi	e, MD	-21229
	Sta Registra		31. Date filed (Month, Day, Year)* MAR 2 3 20	32 Registra	r's Signati	. Sa	Mas					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death March 22, Day 2012 Year Physician/ 4:37 pm Chong Cha Cho Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Howard Gilchrist Hospice Columbia 8. Date of Birth (Month, Day, Yo Oct 24, . Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** Days Months Hours 025-70-0074 74 **Director** 1 □ M 2 🔀 F 1937 Korea Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD 1 ☐ Yes 2X No Howard Columbia 10e. Street and Number 10f. Zip Code ö 10g. Citizen of What Country? 'natural", or items 23a o dical Examiner must be 21045 with 1 Funeral 7080 Cradlerock Way #204 Korea 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) death 12. Was Decedent Ever in U.S. 11 Marital Status 14 Race - American Indian. Armed Forces? Black, White, etc. 1 Never Married 2 Married by within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates 3 X Widowed 4 □ Divorced Specify: Asian Completed Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiens Important: If item 27 is marked other than injury or other traumatic event that the Homemaker Own Home 5 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Tam Gu Kang Man Sue Sul 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DaYoung Cho/daughter 6416 Elffolk Terrace Columbia, MD 21045 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place)
Final Journey Crematory 03/23/12 20c. Location - City or Town, State Woodbine, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Lice Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Ph, sician/ disease or condition resulting in death) Medical Dus to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or injury that initiated events resulting in death) Last burial-tran and Due to (or as a consequence of) Physician/Medical that the death certificate be Box 68760 as the attending IF FEMALE: use ves, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death Pregnant at time of death 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Por Month Day Year g Unknown P.O. p Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 Jas perform Hospital or Attending Physician: The certificate Yes 2 No 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? 2 X No Hospital: 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA ည 4 Nursing Home 5 Residence 6 Other (Specify, After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No in 24 hours after death.

Refuneral Director: All olderly filled in by the fu Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 🞾 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F 29b. Signature and title of certifie D64395 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6336 CEDAR LANE COLUMBIA, MD 21044 DANIEUE DOBERMAN, MA

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day, Year) **NAR 2 3 2012**

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 0906 Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Month 03 COLE G 2: 22AM 2012 Medical 4a. Facility Name (if not institution, give street and num Examiner 4b. City, Town, or Location of Death 4c. County of Death K Maryland Medical University of Baltimore 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth Birthplace (State or Foreign Country) (Month, Day, Year) Director 296-50-4971 1 M 2 XF 58 Aug 3, 1953 Ohio 28a-f show at 10c. City, Town or Location 10d. Inside City Limits Director the Medical Examiner must be notified Howard 1 Yes 2 X No Columbia 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral or items 23a 9013 Ina Court 21045 USA within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 🗶 No 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, þ 1 Never Married 2 X Married Maryland 21215-0036 "natural", If Yes, Give Year or Dates. 1 ☐ Yes 2X No Specify: Specify: White Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b, Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) nd Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4 or 5+) 12 Claim Examiner Insurance 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F is marked or Ronald Robert Glaspell Inez Antoinetta Tiraterra 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) and 2 s Health Important: If item 27 Charles Cole/husband 9013 Ina Court Columbia, MD 21045 Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of 1 Burial 2 X Cremation 3 Removal from State Final Journey Crematory 03/21/12 4 Donation 5 Other (Specify) Woodbine, MD 21. Signature of Funeral Service Linens Going Home Cremation Service P.O. Box 784 MO1251 Beverly L. Heckrotte, P.A. Clarksville 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ lung Cancer disease or condition resulting in death) Medical Examiner Obstruction Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or injury death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) use as the burial-Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No for Month Pregnant at time of death ed by the a detached f 9 W Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>Ş</u> Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autonsy death? 1 Yes 2 No Yes Hospital or Attending Physician: of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 No Other: ျ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural Accident injury 5 Pending Division after death.

Director: Aff
d in by the fu 1 Yes 2 No Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier 1 🗡 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title MD D 69 499 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SHVA GANJI 22 5 GREENE BALTIMORE, MD State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Physician/ 00 P M 2012 JoAnn Cage Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Himore Jauare. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Nov 9, 1937 236-58-3248 Director 1 🗆 M 2 💢 F 74 West Virginia Usual Residence of Decedent ems 23a or 28a-f show r must be notified at 10d. Inside City Limits 28a-f show 10c. City, Town or Location 10a. State 10b. County with the Maryland Director 1 Yes 2 No Harford Joppa MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Numbe Funeral 21085 **USA** 1404 Alexis Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. "natural", or item ledical Examiner n Was Decedent Ever in U.S 11 Marital Status Black White et Armed Forces þ 1 Never Married 2 Married 2 **X**No white Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Completed 3 ☒ Widowed 4 ☐ Divorced Year or Dates the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Department of Health and Mental Hygiene Important: If item 27 is marked other than any injury or other traumatic event, the Me once. College (1-4 or 5+) Elementary/Secondary (0-12) dietitian technician dietary 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ျ Thelma Virginia Henry Clarence Buryl Pennington 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1232 Bon Aire Rd; Forest Hill, MD 21050 19a. Informant's Name/Relationship (Type, Print) Lance D. Huffer - son 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 X Donation 5 Oher (Specify) 22. Name and Address of Facility State Anatomy Board uneral 655 W. Baltimore St; Baltimore, MD 21201 Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of peart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ neumonio Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last physician and stranstrans Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy Month in the past 12 months?
1 Yes 2 X No Day Pregnant at time of death Other (specify) g | Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? page 2 s performed 1 Yes 2 No Yes 2 X N 25. Was case referred to medica 26. Place of Death (Check only one) æ Other: 2 1 🗌 Yes 2 X No 1 X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: 28c. Injury at within 24 hours after death. To the Funeral Director: After 1 Natural 2 Accider 5 Pending 1 🗌 Yes 2 🗌 No Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 3 [only one 29d. Date signed (Month, Day, Year) 29b. Signature and t

State Registrar 31. Date filed (Month, Day,

Year)

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ss of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

James Michael Campbell State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Registrar 1. Decedent's Name (First_Middle Last) 2. Date of Death 3. Time of Death Physician/ Month Day March 18, 2012 Medical Examiner 1122 hrs <u>James Michael Campbell</u> 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death c. County of Death 1822 Briarcliff Road Parkville **Baltimore County** 5. Social Security Number If Under 1 Year I if Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) **Funeral** Days Months Hours Director Country) Maryland 1 X M 218-68-7954 2 F 56 February 02,1956 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits e notified at once. 1 Yes 2 No Maryland Baltimore Parkville Pages I and 2 should be filed within 72 hours after death with the Maryland neur of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f she or other transatic event, ite Markel Examiner must be notified at once 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1822 Briarcliff Road 21234 United States 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? White, etc. 1 Never Married 2 Married 1XX Yes 3 Widowed 4 X Divorced s. Give Year 1 Yes 2 X No specify: Specify: White þ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) 21215-0036 12 Facilities Engineering Computer Security 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be James W. Campbell Lydia R. Neary 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Itimore, MD Colin Campbell (Son) 8213 Evergreen Drive Parkville, Maryland 21234 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State crematory or other place) March 22, Evans Funeral Chapel-Bel 4 Donation 5 Other Specify: Forest Hill, Maryland 2012 21. Signature of Funeral Service License 22. Name and Address of Facility Evans Funeral Chapel & Cremation Services-Parkville 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one clause on each line. Approximate Interval Physician Between Onset and Medical Death a Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as e consequence of): Sequentially list conditions Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause Examine (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last and transit Physician/Medical AMENDED 23a, pt. II, 27, per me, g926 4-19-12 sm X UNPENDED ned by the attending physician detached for use as the burial To the Hospital or Attending Physician: The law requires that the death certificate be Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Fetal death Live birth 3 Ectopic pregnancy Month Day Year past 12 months? 2 Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown 0.0 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? uns certificate has been signed by director, page 2 should be detach 虿 Chronic Alcohol Abuse 1 Yes 2 No 3 Probably 4 Unknown Completed Records, After this certificate has been 24a, Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? 1 🗸 Yes Yes 2 No 25. Was case referred to medical 26.Place of Death (Check only one) Be Division of Vital Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 Other: Scene 1 Yes 2 No 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 X Natural 5 Pending Director: d in by the f 1 Yes 2 No hours after death. 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be or Town, State) determined To the Funeral 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical one) 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) March 19, 2012 O.C.M.E. of 30. Name and address of person who completed cause of death (frem 23a) Zabiullah Ali, M.D. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar

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State of Maryland / Department of Health and Mental Hygiene

Provided Examiner **STANCRORD*** D. COOLEY **STANCRORD*** D. COOLEY **STANCRORD*** D. COOLEY **STANCRORD**** D. COOLEY **STANCRORD**** D. COOLEY **STANCRORD**** D. COOLEY **STANCRORD**** D. COOLEY **STANCRORD***** D. COOLEY **STANCRORD***** D. COOLEY **STANCRORD***** D. COOLEY **STANCRORD***** D. COOLEY **STANCRORD****** D. COOLEY **STANCRORD****** D. COOLEY **STANCRORD****** D. COOLEY **STANCRORD***********************************	,	1- For State Certificate of December 1- For Stat	ath	2012 1906 eg. No.
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2012 ear MARCH CLARK 17 10:20 P M SHIRLEY Μ. 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death MONTGOMERY WASHINGTON ADVENTIST HOSPITAL TAKOMA PARK 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) . Age (In yrs. last birthday) Hours 577-52-4457 75 1 □ M 2 X F JULY 24 1936 WASHINGTON, DC Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 x Yes 2 ☐ No PRINCE GEORGE'S UPPER MARLBORO 10e. Street and Number 10g, Citizen of What Country? 15519 GLASTONBURY WAY 20774 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc 1 Never Married 2 Married 1 Yes If Yes, Give BLACK 1 Yes 2 No Specify 3X Widowed 4 □ Divorced Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) HOMEMAKER PRIVATE 17. Father's Name (First, Middle, Last) 18 Mother's Name (First Middle Maiden Surname) RALPH PRINCE DOROTHY BOWMAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) NETOSHA WASHINGTON/DGT 15519 GLASTONBURY WAY UPPER MARLBORO, MARYLAND 20774 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State MD VETERANS CEMETERY 3/27/2012 CHELTENHAM, MARYLAND 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME, INC. ROAD HYATTSVILLE, MARYLAND 20785 23a. Part f. Interribe disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death 23d. Date of delivery Month Year

Ph_sician/ Medical Examiner and

requires that the death certificate be

Box 68760

P.O.

Division of Vital Records,

or Attending Physician:

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Physician/

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Department of Important: If any injury or once.

Exami Physician/Medical þ Completed Be 임

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To the Funeral Director: After this the filled in by

State

Registrar

29b. Signature and title of certifier

DR. KHALID

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31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE 23b. Was decedent pregnant Live Birth 2 Fetal death 3 Ectopic pregnancy
Pregnant at time of death 5 Other (specify) in the past 12 months?

1 Yes 2 No Day Pregnant at time of death 1 Yes 2 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Hospita 1 Yes 2. No Other: Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? Accident Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifiei

3 🗆 Certifying Nuger Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

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29d. Date signed (Month, Day, Year)

Ctr Drive # 313 Greenbelt MD

DHMH 17 Rev 06-2011

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 Certificate of Death 2. Date of Death Month 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 12:40 A M March 18, 2012 Dieu Khon Chau /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Silver Spring Montgomery Bel Pre Health and Rehabilitation Center Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5 Social Security Number **Funeral** Days 1 X M 2 □ F Vietnam 78 November 20, 586-26-2420 **Director** Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c City Town or Location 10a. State 10b. County d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 1 ☐ Yes 2 X No Director Gaithersburg Maryland Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20882 United States 19906 Manor View Terrace permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a amy injury or other traumatic event, the Medical Examiner must acce. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ሺ No If Yes, Give Year or Dates: 11. Marital Status 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 No Specify Baltimore, Maryland 21215-0036 Specify: þ Asian 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Electronics Stock Clerk 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Nai Thi Ngo Nghiep Chau 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 6400 Brass Bucket Court, Gaithersburg, MD 20882 Minh Chau / Son 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition March 22, 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Montgomery Crematorium, Bethesda, Maryland 2012 4 □ Donation 5 □ Other (Specify) Inc. 22 Name and Address of Facility Robert A. Pumphrey Funeral Home, Bethesda-Chevy Chase, Inc. 21. Signature of Funeral Service Licensee M01619 7557 Wisconsin Avenue, Bethesda, Maryland 20814 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CEREBR Physician /Medical Due to (or es a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed I physician ar s the burial-ti Due to (or as a consequence of): Physician/Medical as t IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnent 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month Year in the past 12 months?
1 □Yes 2 □ No 5 Other (specify) cate has been signed by the page 2 should be detached by 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? After this certificate has autopsy performed 2 □ No 1 □ Yes 1 ☐ Yes 4 26. Place of Death (Check only one) 25. Was case referred to medical Be Other: Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No ours after death. neral Director: A filled in by the fu 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 ☐ Homicide

Division of Vital Records, P.O. Box 68760.

To the within 2

24 hours a

31. Date filed (Month, Day, Year) State MAR 2 3 2012

29a. Certifier

(Check only one)

Medical

29b. Signature end title of certifier

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

20

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Registrar

The age type of Print in Black indelible link. Ensure All Copies Are Legible. amend item 29c per dvr g925 3-26-12 vt State of Maryland / Department of Health and Mental Hygiene AMEND ITEM#/perFH, G925, 3/27/2012, WS 1- State Registrar Certificate of Death Reg. No. 2 2 9 6 9							
Physicia			trell	Month March	20, 2012	3. Time of Death 5:21 A M	
Medic Examin		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of D	4b. City, Town, or Location of Death		4c. County of Death	
		Shady Grove Adventist Hospita1 5. Social Security Number 16. Sex 17. Age (In yrs. last birthda	Rockville	Rockville If Under 1 Year If Under 24 Hrs. 8. Date of Birth		Montgomery 9. Birthplace (State or Foreign	
Funeral Director		5. Social Security Number $\begin{array}{c ccccccccccccccccccccccccccccccccccc$	Months Days Hours 1	Min. (Month, Day March 2	0, 1931 Pen	nsylvania	
and show	tor	10a. State 10b. County 10c. City, Town or	Location			10d. Inside City Limits	
Maryl 28a-f otifiec	Director	Maryland Montgomery	Rockville			1 🗌 Yes 2 🔀 No	
th the	ral D	10e. Street and Number	10f. Zip Code			ountry?	
ems 2	Funeral	4936 Baffin Bay Lane 11. Marital Status 12. Was Decedent Ever in U.S. 1	Was Decedent of Hispanic Origin	Vas Decedent of Hispanic Origin? (Specify Yes or No-		United States 14. Race - American Indian,	
fter de , or it amine	þ	1 Never Married 2 Married Armed Forces? 1 Yes 2 M No	If Yes, specify Cuban, Mexican, P 1 Yes 2 X No Specify:	uerto Rican, etc.)	Black, White	e, etc.	
ours a stural' sal Exa	eted	3 ☑ Widowed 4 ☐ Divorced Year or Dates.			SpecifyWhit		
72 hd an "na Medic	Completed	(Specify only highest grade completed) (G	cedent's Usual Occupation ive kind of work done during most of b. DO NOT use retired)	working	16b. Kind of Business	Industry	
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e filed ntai Hy ed oth eveni	To Be	17. Father's Name (First, Middle, Last)		Name (First, Middle, era Carlss			
ould b		Peter J. Brennan 19a. Informant's Name/Relationship (Type, Print) 19b. M	ailing Address (Street and Number o			2 Codel	
d 2 sho alth an 27 is ir trau		1	00 Stoneridge Co				
of Hear of Hear if item r othe		20a. Method of Disposition 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State 20b. Place of Disposition cemetery, or	sposition (Name of crematory or other place)	Date	20c. Location - City or	Town, State	
. Page tment tant: I jury o		Dullai 2 43 Offination 3 Li Removal nom State	y Crematorium, Inc	arch 23, 2012	Bethesda,	Maryland	
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importants if item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Licensee M01305	Robert A. Pumphrey'r 300 West Montgomery	uneral Home/ Avenue, Rock	Rockville, In ville, Maryla	c. nd 20850-2805	
		23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between					
h, sician/ Medical		Immediate Cause (Final disease or condition resulting in death) Onset and Deformation a. CARDIAC ARRHYTHMIA					
Examiner	Examiner	Due to (or as a consequence of): Sequentially list conditions. Due to (or as a consequence of): HYPOXIC RESPIRATORY FAILURE					
		It any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence or). CADVANCED CHRONIC OBSTRUCTIVE PULMONARY DISEASE					
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oe exe ician a burial-	cal E	resulting in death) Last Due to (or as a consequence of): LUNG CANCER					
physics the last the		d. CONS CANCE	<u> </u>				
ending use a	an/N	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live Birth 2 ☐ Fetal death	3 Ectopic pregnancy		23d. Date of de	livery	
e dearr the att	Completed by Physician/Medi		5 Other (specify)		Month	Day Year	
tnat tn ned by detac	y Ph	Part II. Other significant conditions contributing to death but not resulting in the	ne underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?			
quires en sign	ed b	ATRIAL FIBRILLATION	1 🗆		Yes 2 ☐ No 3 Probably 4 ☐ Unknown		
aw rec as be	plet			24a. Was a	sy prior to	topsy findings available completion of cause of	
cate h				perfo 1 ☐ Yes	rmed? death? 2 No 1 ☐ Yes	2 X No	
sician certifi irector) Be	25. Was case referred to medical examiner? 1					
g Physer this seral d	te: To	27. Manner of Death 28a. Date of injury 28b. Time	e of 28c. Injury at	28c. Injury at 28d. Describe how injury occurred			
endin sath. or: Afti	ficat	1 X Natural 5 ☐ Pending (Month, Day, Year) injui 2 ☐ Accident Investigation	y work? M 1 ☐ Yes 2 ☐ No	0			
or Att after d Direct in by t	Certificate:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (S City or Tow	treet and Number or Ru n, State)	ral Route Number,	
To the hospital or Attending Prlysician; The law requires that the death certificate be executed within 24 hours after death, at after death. To the Funeral Director, After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier (Check (
ithin 2 orthe I	Me	only one) 3 Certifying Nurse Practioner: To the best of my knowledge 29b, Signature and title of certifier		nd place, and due to the	cause(s) and manner as	stated.	
- > - >		Mellau	D-64478			Od. Date signed (Month, Day, Year) MARCH ZO ZO12	
Holm		30. Name and address of person who completed cause of death (Item 23a) (Type	e, Print)	rint)			
State Registrar MAR 2 3 2012 August 1. State Registrar MAR 2 3 2012 August 1. State Registrar Registrar MAR 2 3 2012 August 1. State Registrar Reg						ILLE, MD	
Registra	ar .	MAR 63 CUIL (Keeper) p. gara					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 03Month 1 6ay 20^Yfa2 11:50A M Physician/ Deborah Ann Collins Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A Baltimore Joseph Ritchie Hospice If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** Days Months Hours 218-64-1224 Director 1 □ M 2 □XF Yrs Maryland 03/28/1957 54 Usual Residence of Decedent 10d Inside City Limits 10a. State 10c. City, Town or Location with the Maryland notified at Director 1 ¥ Yes 2 □ No 28a-f Baltimore N/A MD 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number 5 ms 23a or must be r Funeral U.S.A. 21201 817 W. Lexington St. Apt4 items death v 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status th and Mental Hygiene.
27 is marked other than "natural", or iter traumatic event, the Medical Examiner Armed Forces Black White etc. 1 ☐ Yes 2 🙀 No If Yes, Give permit. Page 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or may injury or other traumatic event, the Medical Examinang. by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Specify: Black Completed 3 Widowed 4 Divorced Year or Dates 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15 Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) N/A Unemployed 8th Grade Be 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) ည Auretta Brown Leroy A. Collins 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Coo-19a. Informant's Name/Relationship (Type, Print) 817 W. Lexington St. Apt4, Baltimore, MD Adriene O'neal(sister) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State n-site Crematory 03/19/12 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) ජීර්ප්ප්ර්ති: of PBP own Jr. 2140 N. FUlton Ave., Ignat re of Funeral Service Licenses Funeral Home PA Baltimore, MD21217 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ minter disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate Enter Inderlying Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury sician and e burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical attending physical for use as the t 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) Month in the past 12 months?
1 Yes 2 No Year Dav Pregnant at time of death 9 Unknown been signed by should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 3 Probably 4 Unknown 1 🗌 Yes 2 🗹 No 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? cate has page 2 : performe 1 TYes certificate Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence ၉ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral di 27. Manner of De th 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Certificate: 1 Natural 5 Pending 1 Yes 2 No Accident Investigation 3 Suicide 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗀 29d. Date sighed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Physician/ 4125 PM 2017 COHEN GLADYS Α MARC Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** KESWICK MULTI CARE CENTER BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday, **Funeral** 1 □ M 2 🗓 F Days Hours 0771871921 90 NY Director 155-01-5138 Usual Residence of Decedent 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10c. City, Town or Location Director 1 Yes 2 X No BALTIMORE MD BALTIMORE 10e. Street and Number 10g. Citizen of What Country? Funeral 21208 USA 3403 MIDFIELD ROAD Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 24 No Black, White, etc. 1 Never Married 2 Married Yes ğ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Specify: 3 🕅 Widowed 4 🗆 Divorced WHITE Completed Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) ELECTRICAL ENGINEERING College (1-4 or 5+) Elementary/Seconday (0-12) 12 CONSULTING OFFICE MANAGER Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည SHIELDS SONIA MOGOLEVSKY OSCAR 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3403 MIDFIELD ROAD, BALTIMORE, MD JOYCE BEDINE/DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 Cremation 3 X Removal from State 03/22/2012 FALLS CHURCH, VA KING DAVID MEM GDNS 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shocked heart failure. List only one cause on each line. interval Between Onset and Death Immediate Cause (Final Ph_sician/ erebro - vascular days Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or linjury To the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 yes, outcome of pregnancy
Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Month Year Pregnant at time of death signed by the at d be detached for a Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Algheimers 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? page 2 s autopsy certificate has performed?

1 Yes 2 No 1 Yes 2 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital Other: 4 \(\triangle \) Nursing Home 5 \(\triangle \) Residence 6 \(\triangle \) Other (Specify 2 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work?
1 Yes 2 No 1 X Natural injury 5 Pending 24 hours after death. Funeral Director: Ab Accident Investigation within 24 hours after death

To the Funeral Director: /
completed filled in by the f 3 Suicide 4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie Douwhill 2012 D31025 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Edgerale Road, Baltimore 25 Enthal MD

Registrar DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

32. Registra 's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ **Month** Dean March 5:356 2012 MAI Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Prince George Holy Cross Nursing & Rehab Burtonsville Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours Min. (Month, Day, Year) **Director** 266-46-8316 1 🙀 M 2 🗆 F August 20,1936 75 Florida Usual Residence of Decede 28a-f show 10a. State 10b. County 10c. City, Town or Location notified at 10d. Inside City Limits Director Maryland 1 🗌 Yes 2 😿 No Howard Columbia 10e. Street and Number ö 10f. Zip Code 10g. Citizen of What Country? 1 and 2 should be filed within 72 hours after death with the of Health and Mental Hygiene. I them 27 is marked other than "natural", or items 23a or other traumatic event, the Medical Examiner must be really and the contents. Funeral 6446 Oaken Door 21045 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, rmed Forces? Black, White, etc. δ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. Air Force 1 ☐ Yes 2 X No Specify: Specify. 3 Widowed 4 Divorced Black. Completed Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Computer Specialist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Richard A. Dean Florida Roberts 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ge 1 and 2 short of Health a Donree Dean (Wife) 6446 Oaken Door Columbia, Maryland 21045 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any injury or o 1 Durial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory 3-21-2012 Glen Burnie, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Witzke Funeral Homes, Inc. Maos 5555 Twin Knolls Road Columbia, Maryland 21045 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ etastat disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a nonsequence of): or Attending Physician: The law requires that the death certificate be executed and -tran that initiated events resulting in death) Last physician arest the burial-t Due to (or as a consequence of): Physician/Medical Box 68760 as IF FEMALE: ase 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ for in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death Day Year 1 Yes ZLg Unknown Unknown P.O. signed by t d be detack Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕅 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page performed 2 🗌 No Yes 2 XNo 1 Yes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: မ 1 🗌 Yes 2 📈 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending neral Director; A rilled in by the f 1 Tes 2 No Accident Investigation Suicide Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined To the Hospital within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signatu

State Registrar

31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ Month John Day 7:55 PM 2012 Medical MARCH 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE TOWSON GREATER BALTIMORE MEDICAL CENTE 8. Date of Birth
(Month, Day, Year)
June 24, 1942 If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Maryland 69 **Director** 213-46-4455 1 X M 2 🗆 F Usual Residence of Decede "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 😾 No MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 945 Starbit Rd. 21286 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. by 1 X Never Married 2 Married 1 Yes 2 If Yes, Give Year or Dates Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify Specify: White 3 Widowed 4 Divorced Completed and Mental Hygiene.
Is marked other than "naturaumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) clerk Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Page 1 and 2 should be nent of Health and Menta Winifred D. Duggan Raymond N. Day Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 945 Starbit Rd; Baltimore, MD 21286 Department of Health ar Important: If item 27 is any injury or other trauonce. Winifred Woodbury - sister 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 X Donation 5 Other (Specify) 22. Name and Address of Facility State Anatomy Board Arector 655 W. Baltimore St; Baltimore, MD 21201 . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Minutes. **Examiner** Sequentially liet conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be executed and the burial-tran Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 Se IE FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Pregnant at time of death 2 🗌 No 1 ☐ Yes 2 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part II. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? Yes 2 No 2 🗆 No 1 🗌 Yes 25. Was case referred to medical B 26. Place of Death (Check only one) Hospital 2 X No 1 ☐ Inpatient 2 XER/Outpatient 3 ☐ DOA Other: 1 Yes 잍 4 Nursing Home 5 Residence 6 Other (Specify) funeral Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending ours after death. Ieral Director; Aft filled in by the fu 1 Yes 2 No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 24 hou

To the Fune

completely fi 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certification 29d. Date signed (Month, Day, Year) D-12849

Registrar

State

7600 OSLER Dr. TOWSON, MD 21204

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland			lental Hyg	giene	00075					
			State Registrar	Certificate of E	Death		Reg. No. 2 0	03012					
ı	Physicia		Decedent's Name (First, Middle, Last) RITA DRIVER			2. Date of Dea Month MARCH	Day Year	3. Time of Death 11:43 A M					
	Medic Examin		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or	Location of Death	THROIT	4c. County of Dear						
-		М	MANDRIN HOSPICE		RWOOD		ANNE AR						
	Funeral Director		5. Social Security Number 578-78-5171 Usual Residence of Decedent 6. Sex 1 □ M 2 X F 57	birthday) If Under 1 Year Months Days Yrs.	If Under 24 Hrs. Hours Min.	8. Date of Birtl (Month, Day NOV . 2	v, Year) Co	thplace (State or Foreign untry) YLAND					
	/land f show	tor	10a. State 10b. County 10c. City, To	own or Location				10d. Inside City Limits					
	e Mary r 28a-i notifie	Director	MD PRINCE GEORGE'S BOWI			1	-	1 X Yes 2 □ No					
	th with the ns 23a or must be	Funeral [10e. Street and Number 16010 EXCALIBUR ROAD D009	10f. Zip Code 20716	,		10g. Citizen of What Co	ountry?					
980	rs after dear rral", or iter Examiner	by	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates.	13. Was Decedent of Hi If Yes, specify Cuba 1 Yes 2 No	ın, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit Specify: BI	e, etc.					
21215-0036	s filed within 72 hours after death with the Manyland tal Hygiene. Id Hygiene. Id other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)	6a. Decedent's Usual Occupa (Give kind of work done of life. DO NOT use retired) SECRETARY		ing	16b. Kind of Business.						
Maryland 2		To Be	17. Father's Name (First, Middle, Last) GOLDEN C. DRIVER III		18. Mother's Name		Maiden Surname)						
	12 should be alth and Men 27 is marke r traumatic			9b. Mailing Address (Street a									
nore,	Page 1 and 2 s ment of Health a ant: If item 27 i		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 20b. Place ceme	e of Disposition (Name of etery, crematory or other plac	:e)	Date	20c. Location - City or	Town, State					
Baltimore,	permit. Page 1 a Department of I Important: If its any injury or of		21. Signature of Funeral Service Licensee	22. Name and Addres	ss of Facility J .			L HOME, INC.					
	23a. Part J. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,												
4	Physician/ Medical		shock or hear failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) AMETASTATIC CA					Interval Between Onset and Death					
- Japan	Examiner	jr.	Due to (or as a consequence Sequentially list conditions, b.										
	tuted nd ransit	Examiner	if any, leading to immediate cause. Enter Underlying Cause Unsease or injury that initiated events C.	e of):									
09	cate be executed physician and s the burial-transit	dical E	resulting in death) Last Due to (or as a consequence d	e of):									
. Box 687	ath certifi attending for use a	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal de. 4 ☐ Pregnant at time of death	ath 3 Ectopic pregnanc	y		23d. Date of de Month	livery Day Y ear					
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cords	law requi	Completed				24a. Was a	an 24b. Were au	topsy findings available					
l Re	sician: The la certificate ha rector, page		25. Was case referred to medical	00.01	(D	perfor 1 Yes	rmed? death?	3 2 □ No					
Vita	ysicia is certi direct	To Be	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/	Otho	er: 4 Nursing Ho		ence 6 🛣 Other (Spec	ify) HOCDICE					
Division of Vital Records,	Attending Physician: or death. ector. After this certific by the funeral director,	Certificate:	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation 28a. Date of injury (Month, Day, Year)	o. Time of 28c. Injury injury work'	/ at		ow injury occurred	- INSELEE					
Divisi	al or Atters als after de al Directo ed in by t	. ,	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, building, etc. (Specify)	farm, street, factory, office		28f. Location (St City or Town	treet and Number or Ru n, State)	ral Route Number,					
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funeral	Medical	29a. Certifier (Check only one) 1 X Certifying Physician: To the best of my knowledge only one) 1 X Certifying Physician: To the best of my knowledge only one) 1 X Certifying Physician: To the best of my knowledge only one)	d/or investigation, in my opinio	on, death occurred at	the time, date ar	nd place, and due to the	cause(s) and manner stated.					
	Nith To t		29b. Signature and title of certifier	29c. License		2	29d. Date signed (Monti						
•	78m		30. Name and address of person who completed cause of death (Item 23a CHITRA VENKATRAMAN MD 7300 HANO	a) (Type, Print)	1715	TT WAR	MARCH 21,	ZU1Z					
	Stat Registra	te	31. Date filed (Month, Pay Year) 2012 2. Registrar's Signature	DATE WOO	T GULTUDI	I'IAK I	LLAND ZU//U						
	- region a	.11											

12-02187 Mark Day

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

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Physicia	an/	Decedent's Name (First, Middle,Last)					Date of Deat Month	Day Year	3. Time of Death
ledical Exami	ner	MARK DAY					March 14,	2012	1050 hrs
		4a. Facility Name (if not institution, give street and number) 111 West Road		4b. City,	Town, or Lo	ocation of L	Jeath	4c. County of Dea Baltimore Co	
			(In yrs. last bir		der 1 Year	If Under 2	4Hrs 8 Date of Birt	th (MM/DD/YYYY) 9. E	
Funeral Director				Mont		Hours	Min.	Fore	eigh(ARYLAND country)
	H	218-86-7934	4	3 Yrs.	Щ		08/04	/1968	
any	ŀ		10c. City, Town	or Location	_				10d. Inside City Limits
	اب	MARYLAND N/A	BA	LTIMORE					1 XXYes 2 No
Aaryland 28a-f show 1 at once	Director	10e. Street and Number			p Code		10	og. Citizen of What Co	untry?
th the Maryland 23a or 28a-f sho notified at once	盲	542 BAKER STREET		2	1217			U.S.A.	
with ns 23 be no	Ē	11. Marital Status 12. Was Decedent E	ver in U.S.				? (Specify Yes or No- uerto Rican, etc.)	- 14. Race - Ame White, etc.	erican Indien, Black,
death or ite	Fune	1 Yes 2	X No		_		dorto Modri, oto.,	Specify: BL	V C.K
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hin 72 fe. than edical	ed d		' l	HANDYMA	N			SELF	
d with	Completed	10th grade 17. Father's Name (First, Middle, Last)	- 1	IIANDITIA		3.Mother's 1	Name (First, Middle, M		-
21215-0036 July be filed within 7 Mental Hygiene. marked other than	Be	BERNARD MUNDELL					THEA WILSO		
b, MD 21215-0036 and 2 should be filed within 72 hor feath and Mental Hygiene. item 27 is marked other than "nat traumatic event, the Medical Exi	ျ	19a. Informant's Name/Relationship (Type, Print)						ber, City or Town, Sta	
MD id 2 shoulth and m 27 is summeti		Dorothea E. Wilson/Mother						Md., 2121	
		20a. Method of Disposition 1 X Bunal 2 Cremation 3 Removal from State		of Disposition (Na tory or other place		etery,	Date	20c. Location - City	or Town, State
Baltimore, permit. Pages 1 ar Department of Her Important: If ite injury or other tr	П	4 Donation 5 Other Specify:		MEMORIAL			3-23-12		, MARYLAND
Salti ermit. epartr epartr ijury	u j	21. Signature of u v v v v v v v v v v v v v v v v v v		22. Name and WILLIA	Address of M C B	of Facility ROWN	COMMUNITY	FUNERAL H	OME P.A.
		23a. Part I. Enter the disease, or complications thet caused the	he death. Do r	1 1206 W	NORT	H AVI	ENUE	est shock or heart	Approximate Interval
Physician /Medical		failure. List only one cause on each line.				0011000000		.,	Between Onset and Death
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on of Vital Records, P.O. Box 68760, eading Physician: The law requires that the death certificate be executed ath. or: After this certificate has been signed by the attending physician and the funeral director, page 2 should be detached for use as the burial - transit	Medica	▼ UNPENDED	b,27,28	Ba-f,per	me,g9	926 4-	-25-12 sm		
760, icate be physicate burn	We	IF FEMALE: 23c. If yes, outcome	e of pregnancy]e		23d. Date of delive	
Sox 687 leath certific e attending for use as t	ian	23b. Was decedent pregnant in the past 12 months? 1 Live birth 4 Pregnant at ti		5 Other (Specific Control of the		Ectopic p	regnancy	Month	Day Year
Box 68 e death certificate attending	Physician/	1 Yes 2 No 9 Unknown 9 Unknown		o □ Other top					
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ling Ph After funeral	ü	27. Manner of Death 1 Natural 5 Panding 28a. Date of Injur (Month, Day,Ye	y 28b. ar)	Time of Injury	28c. Injury	_		now injury occurred	
SiOF trend death. ctor:	ät	Accident Investigation 1 td 8-23		1 5:56 pm		s 2 🗶 N			Pural Pauta Number City
Division ral or Attendir rs after death. al Director: A	ertificat	Suicide Could not be		farm, street, factor			or Town, S	tate) 1500_B1k	
Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	ပ	29a. Certifier A Contifue Physicians To the best of my		k of loca				ve. Baltin	
the H Pare	Medical	one) 2 Medical Examiner: On the basis of exam	nination and/or	investigation, in m	ny opinion, c	death occu	rred at the time, date	and place, and due to	the cause(s)
To the comple	Mec	and manner stated. 29b. Signature and title of certifier		29	c. License	number		29d. Date signed (A	fonth, Day, Year)
		Mille Ben W MY)		O.C.M	ιE.		March 17, 2012	2
Dr pera		30. Name and address of person who completed cause of de							
0,6		Melissa Brassell, MD Assistant Medical		900 W. Balti	more Str	reet, Bal	timore, MD 2122	23	
	tate	WALL O O 7017 / /	's Signature	falls	X				
Regis	trar	MAL O J COL COMM	-						

Fenton Philip rueun as PHIENT

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - State of Maryland / Department of Health and Mental Hygiene Registrar Certificate of Death Reg. No. Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Physician/ 9:25 PM S. Fenton Philip 201 March Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Baltimore City 04 sinai Hospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** 213-30-1305 Days Hours 80 Director 1 **X** M 2 □ F MD 08/19/1931 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location Director ıms 23a or 28a-f shı r must be notified a 1 X Yes 2 No Baltimore MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral USA 21209 2211 West Rogers Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, rmed Forces?

X Yes 2 \(\sum \) No 9 þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates. **Korea** "natural" Completed 3 Divorced 4 Divorced the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry **Automobile/Stationary** 15. Decedent's Education (Specify only highest grade completed) Il Hygiene. College (1-4 or 5+) Elementary/Secondary (0-12) Retail Sales **Supplies** Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) of Health and Mental H fitem 27 is marked ot r other traumatic ever ည Beatrice Trail C. Fenton, Jr. Matthew 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trauonce. 2211 W. Rogers Avenue, Baltimore, MD 21209 Sylvia C. Fenton/wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 **X** Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Corp. 03/06/2012 Towson .MD Ruck Towson Funeral Home, Inc. 1050 York Road, Towson, MD 21204 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Peter Amy per dvr. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician/ Pneumonia Asbination disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** sinary Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events Due to (or as a consequence of): Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-trar Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 ding p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 🔀 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an s certificate has b director, page 2 s autopsy performed? Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work?
1 Yes 2 No 28d. Describe how injury occurred 1 Natural injury 5 Pending within 24 hours after death

To the Funeral Director: A
completely filled in by the f 2/ Accident 3 Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, chatter occurred at the time, date and place, and due to the causeign, and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MBBS 03 20/2012 Pramarik KES 000 X 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Vedetrayer Pramanik 31. Date filed (Month, Day, Year)

Registrar DHMH 17 Rev 06-2011

State

MAR 2 3 2012

32. Registrar's Signature

MBBS, Sinei Hospital of Baltimore, 2401 W Betredere Are. Bultimore

MD-21215

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 1 - For State Reg. No. 20 Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death March Month Physician/ Year 0400 AM Claire Rae Ferreri Medical 4a. Facility Name (if not institution, give street and number) 4b. City Town, or Location of Death Examiner 4c. County of Death tanes HOSPITAL baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours (Month Day, 1^{Year)} 1 M 2 X F Min. 219-18-0948 Yrs MD **Director** 85 May Usual Residence of Decedent 28a-f shov d Mental Hygiene. marked other than "natural", or items 23a or 28a-f sho matic event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City. Town or Location with the Maryland 10d. Inside City Limits Director 1 Yes 2x No MD Catonsville Balitmore 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 21228 USA 227 Worthmont Road permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items: any injury or other traumatic event, the Medical Examiner musonce. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. ģ 1 Never Married 2 K Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: Completed White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဥ Ruby Phillips Wrightson Tyler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 227 Worthmont Road; Catonsville, MD 21228 Frank S. Ferreri, Sr. Husband 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Druid Ridge Cemetery 1 X Burial 2 Cremation 3 Removal from State 3/19/2012 Pikesville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 21. Signature of Funeral Service Licenses 1630 Edmondson Avenue; Catonsvil 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Pulmonary Embolism 1 In 23 Between Onset and Death Pulmonary Embolism Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a Cardiac Arrest Day Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Exami Day Respiratory Failure burial-tran that initiated events resulting in death) Last and Due to (or as a consequence of): e attending physician and for use as the burial-Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? Month Dav 5 Other (specify) Year Pregnant at time of death signed by the aid Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Wiknown Completed should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has page 2 : autopsy 1 Yes 2 No Yes 2X N 25. Was case referred to medical examiner? Division of Vital completed filled in by the funeral director, 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) မှ 1 Yes 2 No 1 Ninpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manne Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred iniury 1 V Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined City or Town, State) Medical 1 🗵 👉 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and 29c. License numbe 29d. Date signed (Month, Day, Year) of person who completed cause of death (Item 23a) (Type, Print) gar 30. Name and address Mohamed 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death March 15^{Day} 20 TZ Physician/ 2:10 Ам Rodman Alford Green Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Genesis Hamilton Nursing Center Baltimore 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Social Security Number **Funeral** Hours Feb 5, 1955 Min Maryland **Director** 57 217-64-3922 1 X M 2 - F Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County Director 1 Yes 2 X No Havre de Grace Harford MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Numbe Funeral USA 21078 556 Franklin St. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces? 1 ⚠ Yes 2 ☐ No If Yes, Give Black, White, etc. 1 X Never Married 2 Married 2 Baltimore, Maryland 21215-0036 black 1 ☐ Yes 2 X No Specify. 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry unk Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 1aborer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Levi Green Areray Watson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 6928 Wadsworth Pl; Fayetteville, NC 28314 Annie Kellie - sister 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 □ Donation 5 🛪 Other (Specify) in state Signature of Fun at price Licensee Onald Street Onald Str 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore St; Baltimore, MD 21201 Approximate Interval Between Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be as the IF FEMALE use Live Birth 2 Fetal death 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months 1 Yes 2 No for Month Pregnant at time of death n signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 ☐ No 3 ☐ Probably 4 ☐ Unknown ate has been signated by page 2 should b 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed 1 Yes 2 No Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) director မ 1 Tyes 2 100 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 I 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: After 1 Natural work? 5 Pending 1 Yes 2 No n 24 hours after death.

E Funeral Director: A letely filled in by the fu Accident Investigation 6 Could not be 3 Suicide
4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined

Division of Vital Records, P.O. Box 68760

State Registrar

within 24 hor To the Fune completely f

Medical

29a. Certifier

29b. Signature

(Check

only one)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 234 pM prosse 2012 March h Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 17 4 Hopkins Hospital Himore Johns If Under 24 Hrs Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex Age (In yrs. last birthday) **Funeral** (Month, Day, Year) 214-02-8888 1 □ M 2 🏝 F Director 44 May 5, 1967 Washington, D.C. show 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County within 72 hours after death with the Maryland Director or 28a-f sl 1 Yes 2 X No **Fulton** Maryland Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 must be 20759 U.S.A. 23a Funeral 7584 Pindell School Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12, Was Decedent Ever in U.S Armed Forces? 11. Marital Status ıral", or iten I Examiner ı Black, White, etc. ð 1 Never Married 2 X Married 1 ☐ Yes 2 🛣 No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: "natural", 3 Widowed 4 Divorced White Completed Year or Dates event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) n 27 is marked other than "n r traumatic event" Elementary/Secondary (0-12) College (1-4 or 5+) Tree Company Self Employeed Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 1 and 2 should be fill if Health and Mental item 27 is marked o ည Florence McGuire Anthony Barbera 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (Father) 4301 Oakwood Landing Court Dayton, Maryland 21036 Anthony Barbera item 2 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition Date permit. Page 1 a
Department of F
Important: If ite
any injury or otl
once. cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 3-23-2012 Silver Spring, Maryland Gate of Heaven Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Witzke Funeral Homes, Inc. MOIOSD 5555 Twin Knolls Road Columbia, Maryland 21045 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final RESPIRATION Ph, i jan/ disease or condition Medical resulting in death) Due to (or as a consequence of Examiner PUFUMONI Samontielly bet e-visitions Examiner if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician Physician/Medical The law requires that the death certificate be Box 68760 IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 Yes 2 No Month ρ Day Year Pregnant at time of death should be detached Unknown 9 Unknown P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performe death? 1 Yes 2 No this certificate Yes Hospital or Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA မ 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death nours after death.

neral Director: After the filled in by the funera 28c. Injury at 28d. Describe how injury occurred Certificate: injury work? 1 ☐ Yes 2 ☐ No Natural
Accident 5 Pending M 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) within 24 hours a

To the Funeral C

completely filled Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Alurse Practitioner: To the best of my knowledge, death occurred at the lime, date and place, and due to the cause(s) and manner as stated

State Registrar 29b. Signature and title of certific

31. Date filed (Month, Day Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) /A

RE(

DHMH 17 Rev 06-2011

29c. License number

600 Yorth wolfe

es - 00

2012

21287

March

Street Bathmore

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For	State of Ma	aryland				nd Mental Hy	20	12	nonsi
			Registrar 1. Decedent's Name (First, Middle	, Last)	,	Cei	rtificate of	Deam	2. Date of De		16	3. Time of Death
	Physicia /Medic		Vincent	Grance	de				Month O3	14 2	Ye ar	920Pm
	Examin	er	4a. Facility Name (If not institution	give street and number)	ADVIN	SAX	4b. City, Town, o	r Location of	Death	4c. Count		h
	Funeral		5. Social Security Number 219–03–3370	6. Sex 7. Ag	e (In yrs. la	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 2	4 Hrs. 8. Date of Bir Min. Month, Da JULY 2	th ry, Year)		hplace (State or Foreign untry) YLAND
	Director		Usual Residence of Decedent	Α					3011 2	,1919	FIRM	
	/larylar f show	or	MD • 10b. County	BALTO.	10c. City	, Town or Lo	cation NOTTINGH	ΔМ				10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	th the l	Director	10e. Street and Number				10f. Zip Code			10g. Citizen of		untry?
	sath wi	Funeral [2 HILLGATE CO	URT	Ever in LLS	12	2123		in? (Specify Yes or No		SA Se Ame	rican Indian,
ထ္	after de or item miner		11. Marital Status1 ☐ Never Married 2 ☐ Marri	Armed Forces?			If Yes, specify Cub	an, Mexican, Specify:	Puerto Rican, etc.)		ack, White	
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Maryland 21215-003	S should be filed and Mental Hygi is marked other aumatic event, I	To Be	FRANK P. GRAND	•		_			LIA DEFINA			
Mar	· · · ·		19a. Informant's Name/Relationsh						r or Rural Route Numb	_		
re,	es 1 and of Health I item 27 r other to		SANDRA FIORENZ 20a. Method of Disposition			1	LGATE CO sition (Name of matory or other pla		Date Date	20c. Location		
			1 ☐ Burial 2 ⚠ Cremation 4 ☐ Donation 5 ☐ Other (Sp	pecify)		TLANTI	C CREMAT	ORY 3	-17-2012	GLEN B	URNT	E, MD
Bai	permit. Page Department Important: I any Injury o		21. Ignature (Funeral 9 vice	icensee		22	 Name and Address 9705 BEL 		SCHILLONG	FUNERA		-
			23a. Part). Enter the disease, or shock, or heart failure. List	complications hat care econy one cause on ear li	d the death	n. Do not en					ш.	Approximate Interval Between
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Box 6	eath certific attending p for use as	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome			7			23d. D	ate of de	livery
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٠ <u>.</u>	res that th signed by be detach		Part II. Other significant condition	ons contributing to death b	out not resu	ulting in the u	nderlying cause gi	ven in Part I.	23e. Did	tobacco use co	ntribute to	the cause of death?
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Division of Vital	the Hospital or Attending Physician: The law requires that the death certificate be executed hin 24 hours after death. The Funeral Director: After this certificate has been signed by the attending physician and impletely filled in by the funeral director, page 2 should be detached for use as the burial-transit.	Certification:	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determ		ury - At ho c. <i>(Specif</i>	ome, farm, st	reet, factory, office			(Street and Nur wn, State)	nber or R	ural Route Number,
	To the Hospital or within 24 hours after To the Funeral Dir completely filled in			g Physician: To the best								
	the Hothin 24 the Fu	Medical	(Check only one) 2 Medical Medical 29b. Signature and title of certifier	Examiner: On the basis of and manner st		tion and/or if		opinion, dea	th occurred at the time	29d. Date sign		
	6 2 ½ 3 \ \ \		255. Signature and the or certifier	TRNP-FI	JP -	BC	R	176	820	02/1	6/2	2072
1	2 / 18h		30. Name and address of person	who completed cause of	death (Item	1 23a) (Type,	Print) IEMI	TOPE	WILLIAM	NS 11	~	
	Sta	te	31. Date filed (Month, Day, Year)	22. Regist	rar's Signa	ture par	4.1	- 1110	12123	+ -		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year 2 Physician/ 0535 Mar 101 ax <12015mla Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Examiner Kockville ומכי נת 140000 Casey If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Social Security Number 6. Sex **Funeral** Hours (Month, Day, Year) 450-62-0660 89 Director 1 □ M 2 🗓 F July 7, 1922 Mexico Usual Residence of Deced 23a or 28a-f show 10d. Inside City Limits aţ 10a. State 10c. City, Town or Location Director must be notified 1 ☐ Yes 2 X No MD Montgomery Germantown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 20874 13207 Dariymaid Dr. Apt. T-1'natural", or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11. Marital Status event, the Medical Examiner Black White etc. by 1 X Never Married 2 Married Yes Yes Baltimore, Maryland 21215-0036 1 ☑ Yes 2 ☐ No Specify: Mexican White Specify 3 Divorced 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. College (1-4 or 5+) Elementary/Secondary (0-12) Tailoring / Clothing Seamstress 6 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ (Unknown) (Unknown) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13207 Dairymaid Dr. #T-1, Germantown, MD 27 Maria F. Nagy / Sister permit. Page 1 and 2 Department of Healt Important: If item 2 or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2XX remation 3 Removal from State Chesapeake Crematory | 03/23/2012 Beltsville, MD injury o 4 Donation 5 Other (Specify) Rapp Funeral and Cremation Services any 933 Gist Ave., Silver Spring, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Betwe Shap (Immediate Cause (Final disease or condition Physician/ omo Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, example to incrediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to jor as a consequence of and -trar Due to (or as a consequence of): attending physician for use as the burial Physician/Medical that the death certificate be Box 68760 yes, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy

Support at time of death 5 Other (specify) IF FEMALE: 23d Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 9 Unknown P.O. I ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an has 1 Yes 2 No certificate or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be xaminer? Other: 4 Nursing Home 5 Residence 6 X Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 24 hours after death. Funeral Director: After this filled in by the funeral 28b. Time of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28d. Describe how injury occurred Certificate: ☐ Natural 5 Pending of altrops un 1 ☐ Yes 2 No 2 Accident 3 Suicide Un KM Investigation 6 Could not be mar 17 2012 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number of Rural Route City or Town, State) determined NUMBER Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 💢 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) within 2 To the I 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year) 14320 20 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DEBRAH MILLER, CRNP: 6001 MUNCASTER MILL RD., ROCKVILLE, MD 20854 31. Date filed (Month, Day, Year)
NAR 2 3 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2 Date of Death Decedent's Name (First, Middle, Last) 3. Time of Death 03711/201³2 Physician/ Nadezhda Georgievskaya 05:10 a M Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Montgomery Foxchase Nursing Home Silver Spring 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. . Social Security Number 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** Hours 0571671922 Months 1 🗆 M 2 💢 F Russia 89 578-35-2392 Director Usual Residence of Decedent ır than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a, State death with the Maryland Director Silver Spring 1 Yes 2X No MD Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 20910 USA 2015 East-West Highway Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces? Black, White, etc. ş 1 Never Married 2 Married Specify: White 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NQT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) 2 should be filed within 72...th and Mental Hygiene.
7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) Teacher Education Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Michael Georgievskiy Zoya Georgievskaya 1 and 2 should be feelth and Meitem 27 is mark 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 302 N Street SW Washington DC 20024 Igor Appel or other 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a
Department of P
Important: If ite
any injury or of cemetery, crematory or other place) 1 ☐ Burial 2 【 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 03/16/12 Atlantic Crem Glen Burnie MD 21. Signature of Foweral Service Licensee Simplicity Crem & Fun Service 7090 Ridge Rd Hanover MD Thomas Allen P.A. 11om 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Cardiopulmonary Arrest Phylician/ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Dementia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): Chronic Obstructive Pulmonary Disease burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Hypertension Division of Vital Records, P.O. Box 68760 as the IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown nse 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year for in the past 12 months? Month Day 5 Other (specify) 1 Yes 2 No signed by the a 23e. Did tobacco use contribute to the cause of death? Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. ş 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 XUnknown cate has been signated by page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of autopsy certificate has performed' death? 2 **X**No 1 🗌 Yes Yes 2 No 26. Place of Death (Check only one) director, 25. Was case referred to medical Be examiner? Other: 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 4 X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) မ after death.

Director: After this filled in by the funeral 28b. Time of 28c. Injury at 27. Manner of Death 28a. Date of injury 28d. Describe how injury occurred Certificate: 1 Natural (Month, Day, Year) injury work?
1 ☐ Yes 2 ☐ No 5 Pending Investigation Accident 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Suicide 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 24 hours a Funeral I Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated completed 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the I the 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 29c. License number 2 03/15/2012 D0067092

DHMH 17 Rev 7/2009

State

Registrar

15245 Shady Grove Road Suite 130 Rockville MD 20850

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Weihan Wang

MAR 2

31. Date filed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Rosalie J. Holland March 21, 2012 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 500 Barwick Court Belair Harford Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth Months (Month, Day, Year) 4-29-1943 Days Hours Min. 212-44-2957 Director 68 1 M 2 X F Baltimore, MD Yrs. Usual Residence of Decedent or 28a-f show 10b. County "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10c. City, Town or Location Director MD Harford Belair 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 500 Barwick Court 21014 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12:46 Armed Forces' Black, White, etc. 1 Yes 2 No 1 Never Married 2 Married <u>م</u> Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes. Give 3 → Widowed 4 □ Divorced Specify: Completed d 2 should be filed within 72 hours a aith and Mental Hygiene. 127 is marked other than "natural er traumatic event, the Medical E) Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) analyst Department of Army College (1-4 or 5+) Management Program Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Milton Borzymowski Mary Giordano 19a. Informant's Name/Relationship (Type, Print) daughte; 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary J. Holland Steel Rd., Havertown, 414 PA. 19083 permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other: 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 3/24/2012|Baltimore,Maryland Oak Lawn 21. Signature of Funeral Service License 22. Name and Address of Facility Joseph N. Zannino Jr. arua 263 S. Conkling St.Baltimore, MD 21224 23a. Part 1. Enter the disease, or control cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only Immediate Cause (Final disease or condition Lungcancer Physician Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or injury attending physician and I for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death Month Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Follan Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an or Attending Physician; The law has autopsy 1 🗌 Yes 25. Was case referred to medical e e 26. Place of Death (Check only one) examiner? 1 Yes 2 No 27. Manner of Death Other: 4 Nursing Home 5 Residence မ Sosalie 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) Certificate: 28c. Injury at work?
1 Yes 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending within 24 hours after death

To the Funeral Director: A

completely filled in by the 1 Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

12:46pM

9. Birthplace (State or Foreign

White

10d. Inside City Limits

Approximate Interval Between Onset and Death

2 No

ulane, Valley Pd Timonium, MD 21093

1 ☐ Yes 2 🛂 No

Registrar DHMH 17 Rev 06-2011

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 1⁹ 2012^{ear} MARCH HORNE 5:53 A M JR. LOVE Α. 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death PRINCE GEORGE'S CHEVERLY PRINCE GEORGE'S HOSPITAL If Under 1 Year If Under 24 Hrs. g. Birthplace (State or Foreign Country) Social Security Number 8. Date of Birth 7. Age (In yrs. last birthday) Days Hours Min (Month, Day, Year, Months 105-22-9939 1 🕱 M 2 🗆 F 21 1929 NORTH CAROLINA DEC. Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 X Yes 2 No PRINCE GEORGE'S LANDOVER MD 10f. Zip Code 10e Street and Number 10g, Citizen of What Country? USA 20785 7020 FLAGSTAFF STREET Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces? 1 Yes 2 No Black, White, etc. 1 Never Married 2 Married 1 XYes 2 If Yes, Give Year or Dates BLACK 1 ☐ Yes 2 🗓 No Specify: Specify. 3 Widowed 4 Divorced Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4 or 5+) Elementary/Secondary (0-12) PRIVATE CYLINDER FILLER 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) WATSON LULA LOVE A. HORNE SR. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7020 FLAGSTAFF STREET LANDOVER, MARYLAND MARY H. HORNE/WIFE 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State LANDOVER, MARYLAND 3/24/2012 HARMONY CEMETERY 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME, INC. 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ATA disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectonic pregnancy in the past 12 months? Month Day 5 Other (specify) 4 Pregnant at time of death

Physician/ Medical Examiner

Physician/

Medical

Director

Funeral

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Completed

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Examiner

Funeral

Director

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permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items: any injury or other traumatic event, the Medical Examiner must once.

Baltimore, Maryland 21215-0036

notified

with the Maryland

burial-transi physician the as use jo the a after deat Director: by

Division of Vital Records, P.O. Box 68760

Examine Physician/Medical þ Completed Be မ Medical Certificate:

g 🗌 Unknown	9 LJ Unknown	
Part II. Other significant conditions o	ontributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 □ Yes 2 No 3 □ Probably 4 □ Unknown
		24a. Was an autopsy performed? 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No
25. Was case referred to medical	26. Place of Death (Check	only one)
examiner? 1 ☐ Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Ho	me 5 Residence 6 Other (Specify)
27. Manner of De h 1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year) injury work? M 1 ☐ Yes 2 ☐ No	28d. Describe how injury occurred
3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
(Check 2 Medical Exam	sician: To the best of my knowledge, death occurred at the time, date and place, ar ner: On the basis of examination and/or investigation, in my opinion, death occurred at se Practitioner: To the best of my knowledge, death occurred at the time, date and pla	the time, date and place, and due to the cause(s) and manner stated

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours at To the Funeral D completely filled it

Eu,

Registrar

GRIFFIN DAV 15 31. Date filed (Month, Day, Year, State

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number D63688 29d. Date signed (Month, Day, Year) 2012

YID

MD CHEVELLY 20785

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 8 per fh g926 4-17-12 vt. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 26 17 Hall 50A M Ventelle 12: March Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE RANDALLSTOWN SEASONS HOSPICE Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 6. Sex If Under **Funeral** (Month, Day 1929 Months Hours **Director** 212-36-8327 1 🗆 M 2 🗶 F 82 $11/06 \frac{/20}{}$ MARYLAND Usual Residence of Deced 28a-f show and 2 should be filed within 72 hours after death with the Maryland 10a. State 10h. County 10c. City, Town or Location 10d. Inside City Limits notified at Director 1 Yes 2 X No RANDALLSTOWN MD BALTIMORE 10e Street and Number 10f. Zip Code 9 10g. Citizen of What Country? must be 23a Funeral 21133 3711 COURTLEIGH DR. U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2X No Examiner Black, White, etc. ò þ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: 3 Widowed 4 Divorced Completed BLACK the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b Kind of Business/Industry (Give kind of work done during most of working life DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) HEALTH 12 NURSING ASSISTANT Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental H 2 BERNICE HAWKINS JESSE HAWKINS other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ant of Health a it: If item 27 is y or other tra 3711 COURTLEIGH DR. RANDALLSTOWN, MD 21133 AUDREY COUSER-NIECE Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Page 1 a cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Department of Important: If any injury or ARBUTUS MEM. PARK 03/24/2012 BALTIMORE, MD 4 Donation 5 Other (Specify) Signatur Fundal ervice Licensee WILLTAM C. BROWN COMMUNITY FUNERAL HOME P.A. 1206 W. NORTH AVE. BALTIMORE, MD 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Lung cancer Ph_sician/ disease or condition Medical resulting in death) Due to (or as consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last and Due to (or as a consequence of) Physician/Medical that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 page 2 To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ု 1 🗌 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work?
1 Yes 2 No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier

State Registrar

IV

(Check

29b. Signature and title of certifier

MAR 23

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NS RW aparts MO 7835 SMM AV 570

32

5 703

Certifying Nurse Practitioner: Title cost of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: Title cost of my house of an anner stated.

00057 465

Baltimore MD 21709

29d. Date signed (Month, Day, Year)

3/16/12

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 3. Time of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) 29 Month Physician/ Haber Kan 0 Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Bactimor Balt 2/22 2000 9. Birthplace (State or Foreign 8. Date of Birth Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Funeral Days Min. ^{Country)}aryland 1 XM 2 □ F Months Hours (Month Pay / 1960 213-84-1919 52 Yrs Director Usual Residence of Decedent 10d. Inside City Limits or 28a-f shov 10a State 10c. City, Town or Location with the Maryland Examiner must be notified at Director 1 Yes 2 No Dundalk Baltimore MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral items 23a 21222 **USA** 1518 Leslie Road filed within 72 hours after death v Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. 11, Marital Status Armed Forces?
1 ☐ Yes 2 🛛 No Black, White, etc. "natural", or à 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛚 No Specify If Yes Give White 3 Widowed 4 Divorced Completed Year or Dates other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 16b Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) during most of working marked other than Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other tha any injury or other traumatic event. The Na. Mechanic Automotive Be 18. Mother's Name (First, Middle, Malden Surname) 17. Father's Name (First, Middle, Last) Gloria M. Cramer John B. Haberkam 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Gloria M. Haberkam / Mother 1518 Leslie Road, Dundalk, MD 21222 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 1 Burial 2 Cremation 3 Removal from State 3/22/2012 Beltsville, MD Chesapeake Crematory 4 Donation 5 Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Maryland Cremation Services, PO Box 1413Baltimore, MD 21203 Dorota Marshall 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final dementia Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury attending physician and for use as the burial-transit that initiated events resulting in death) Last Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23d. Date of delivery 23b. Was decedent pregnant 3 Ctopic pregnancy
5 Other (specify) Live Birth 2 - Fetal death Month Day Vear in the past 12 months? Pregnant at time of death 2 🗌 No been signed by the s 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autons page 2 this certificate has death? 1 Tyes 25. Was case referred to medical examiner? 26. Place of Death (Check_only one) Hospital or Attending Physician: the funeral director, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Tyes ER/Outpatient 3 DOA ္ 1 🗌 Inpatient 2 🖫 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Certificate: After 1 Natural work 5 Pending 1 Yes 2 No Accident Investigation 24 hours after deat Funeral Director: 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide filled in by determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated completed (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 3 [within 2 **To the I** only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie n.ar-O Krown 20,2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 7/2009

State

31. Date filed (Mon

Entere stree

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) March Physician/ 2012 3:00 \mathbf{A}^{M} Emily Inskeep Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Harford Bel Air 117 N. Lynbrook Rd. 9. Birthplace (State or Foreign 8. Date of Birth If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Nov 26ay, Year 932 Hours Maryland 79 Director 211-26-1329 1 □ M 2**X** F Usual Residence of Decede 10d. Inside City Limits 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at genee. 10a. State 10c. City, Town or Location Director 1 Yes 2 No Bel Air MD Harford 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral USA 21014 117 N. Lynbrook Rd. . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Black, White, etc. by 1 Never Married 2 X Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify If Yes, Give 3 Widowed 4 Divorced Completed Year or Dates 16b. Kind of Business/Industry unk 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) administrative Be 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) 2 Martha Jane Bradley Harrison Martin Kyle 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 117 N. Lynbrook Rd; Bel Air, MD 21014 William Inskeep - husband 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 🗋 Burial 2 🗌 Cremation 3 🔲 Removal from State 4 X Donation 5 Other (Specify) 22. Name and Address of Facility State Anatomy Board Signar e of Euner a rvice Lice Make, Director 655 W. Baltimore St; Baltimore, MD 21201 11 art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between ock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final angestive Physician/ disease or condition Medical resulting in death) Due to (o s a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) executed and Due to (or as a consequence of): attending physician a for use as the burial Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 9 I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy performed? Yes 2 No 1 🗌 Yes 2 🔲 No within 24 hours after death.

To the Funeral Director: After this certificate 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital Other: 1 ☐ Yes 2 W No 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural injury 5 Pending Accident Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29d. Date signed (Month, Day, Year)

State Registrar 29b. Signature and title

31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print

Johnson, Deandre, A

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			_ State		ificate of L			0010	nanan
			Registrar 1. Decedent's Name (First, Middle, Last)		meate of E	Jean	2. Date of De	Reg. No.	3. Time of Death
н	Physicia		De'Andre Antonio Johns	on,Sr.			Month	Day as Year	4:36PM
-	Medic Examin		4a. Facility Name (if not institution, give street and number)		4b. City, Town, or	Location of Death	100	4c. County of Deat	
أرسا			Sinai Hospital of Bal	Finore	Balt	inore	City		
	Funeral Director			n yrs. last birthday)	Months Days	Hours Min.	8. Date of Sir (Month, Da Feb. 2	th ly, Year) 9. Bir Co 23 , 1979 M	thplace (State or Foreign untry) Iaryland
	aryland a-f show fied at	Director		Dc. City, Town or Loca				-	10d. Inside City Limits Yes 2 No
	or 28 or or 28		10e. Street and Number		10f. Zip Code		1	10g. Citizen of What Co	puntry?
	with the state of	Funeral	5805 Key Avenue		2121	5		USA	
980	ge 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at.	by	11. Marital Status 1 X Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever Armed Forces? 1 Yes, 2 No If Yes, Give Year or Dates.	If Y	as Decedent of H Yes, specify Cuba	ispanic Origin? (Spe in, Mexican, Puerto Specify:	cify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify: Bla	4
2-0	2 hour	plet	15. Decedent's Education (Specify only highest grade completed)		ent's Usual Occup	ation during most of worki	na	16b. Kind of Business/	Industry
Maryland 21215-0036	d within 73 ygiene. her than it, the Me	Be Completed	Elementary/Secondary (0-12) College (1-4 or 5+) 12th grade	life. DO	NOT use retired) k Hand l	er		McDonalds	
yland	should be filed n and Mental Hy, r is marked oth raumatic event	To B	17. Father's Name (First, Middle, Last) Andre Johnson, Sr.			18. Mother's Name Doretha	Brown	L	
	and 2 shou Health and tem 27 is m		19a. Informant's Name/Relationship (Type, Print) Doretha Johnson/Mother			and Number or Rura enue Bal	Route Number	e, City or Town, State, Zi , Maryland	
Baltimore,	permit. Page 1 and 3 Department of Healt Important: If item 2 any injury or other once.		1 Material 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. Place of Disposi cemetery, crema King Memo	ition (Name of atory or other plan OTIAL	ark 3/2	8/12 V	20c. Location - City or Jindsor Mi	Town, State
Balt	permit. Par Departmer Important any injury once.	1	21. Signature of Funeral Service License	^{22.1} 52	Name and Addres	^{ss of Facility} Cha sterstow	tman-H n Rd E	Harris Fun Baltimore,	eral Home MD 21215
	Medical Examiner	0 0	23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a condition or should be condition)	Ischai	the mode of dyin	g, such as cardiac c	r respiratory ar	rest,	Approximate Interval Between Onset and Death
09	ecuted and Il-transit	dical Examiner	Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a condition of the condition of the cause) Due to (or as a condition of the cause) Due to (or as a condition of the cause) Due to (or as a condition of the cause) Due to (or as a condition of the cause) Due to (or as a condition of the cause) Due to (or as a condition of the cause) Due to (or as a condition of the cause) Due to (or as a condition of the cause) Due to (or as a condition of the cause) Due to (or as a condition of the cause) Due to (or as a condition of the cause) Due to (or as a condition of the cause) Due to (or as a condition of the cause) Due to (or as a condition of the cause) Due to (or as a condition of the cause) Due to (or as a condition of the cause) Due to (or as a condition of the cause) Due to (or as a condition of the cause) Due to (or as a condition of the cause) Due to (or as a condition of the cause) Due to (or as a condition of the cause) Due to (or as a condition of the cause) Due to (or as a condition of the cause) Due to (or as a condition of the cause) Due to (or as a condition of the cause) Due to (or as a condition of the cause) Due to (or as a condition of the cause) Due to (or as a condition of the cause) Due to (or as a condition of the cause) Due to (or as a condition of the cause) Due to (or as a condition of the cause) Due to (or as a condition of the cause) Due to (or as a condition of the cause) Due to (or as a condition of the cause) Due to (or as a condition of the cause) Due to (or as a condition of the cause) Due to (or as a condition of the cause) Due to (or as a condition of the cause) Due to (or as a condition of the cause) Due to (or as a condition of the cause) Due to (or as a condition of the cause) Due to (or as a condition of the cause) Due to (or as a condition of the cause) Due to (or as a condition of the cause) Due to (or as a condition of the cause) Due to (or as a condition of t	,	pus C	eyma	na:to	sus	5 years
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fΝ	Physi this c	2	1 Yes 2 No 1 Impatient 27. Manner of Death 28a. Date of injury	2 ER/Outpatient 28b. Time of		4 LI Nursing Ho		dence 6 Other (Spec	rify)
0 1	ding I h. After funer	ate	1 ☑ Natural 5 ☐ Pending (Month, Day, Ye	ear) injury	28c. Injury work M 1 🗆		28a. Describe i	now injury occurred	
Division of Vital Records,	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined 28e. Place of Injury building, etc. (S	- At home, farm, stree Specify)			28f. Location (S City or Tov	Street and Number or Ru vn, State)	ral Route Number,
	e Hospita 24 hours e Funeral	Medical	29a. Certifier 1 Certifying Physician: To the best of my (Check 2 Medical Examiner: On the basis of exam only one) 3 Certifying Nurse Practitioner: To the be	nination and/or investig	gation, in my opinio	on, death occurred at	the time, date a	and place, and due to the	cause(s) and manner stated
	To the withing to the comp	2	29b. Signature and title of certifier	7	29c. License	e number		29d. Date signed (Monti	
	1		Ham, MBBS		RES	-000		March 2	3,2012
	P lin		30. Name and address of person who completed cause of death	h (Item 23a) (Type, Pri	int)		ALTIM		
ı	Sta Registra		31. Date filed (Month, Day, Year) NAR 2 3 2012 32. Registrar's						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ March 2012 14 12:45 PM Janie Marie Jackson Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore Joseph Richey Hospice If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Dec 15, Months North Carolina **Director** 216-84-3102 47 1 □ M 2 🗓 F 'natural", or items 23a or 28a-f show dical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Tyres 2 No MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21223 USA 304 N. Carrollton Ave. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian. Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 Specify: black 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates 3X Widowed 4 □ Divorced Completed permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturally injury or other traumatic event, the Medicall once." 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) hospitality housekeeping Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Jeanette Bobbett 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 304 N. Carrollton Ave; Baltimore, MD 21223 19a. Informant's Name/Relationship (Type, Print) Taves Powell - cousin 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) ☐ Burial 2 ☐ Crema 3 Removal from State 4 Donation of Other (Specify) in state 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore St; Baltimore, MD 21201 nter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, If heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Carse (Final Ph_sician/ disease or condition resulting in death) POR Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or injury Due to for as a guissionen of: attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an 2 🗌 No 1 Tyes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director, After this certific completely filled in by the funeral director, Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: Other: 2 No 1 Tes ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Manne of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No M Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier 🖫 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kachel Levine 5200 2300 Eastern MFL Blog 31. Date filed (Month, Day, Year). - - · State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 3 i OM Physician/ 001 KAYLOR Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Anne Arundel Medical Center Annapolis If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Months (Month, Day, Year) 246-32-1478 Director 1 M 2 F 85 Sept. 1, 1926 North Carolina 28a-f shov 10b. County 10c. City, Town or Location 10d. Inside City Limits event, the Medical Examiner must be notified at Director Edgewater 1 ☐ Yes 2 🂢 No Marvland Anne Arundel 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? or items 23a or Funeral 21037 United States 3417 Swallowtail Court 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Black, White, etc. ģ 1 Never Married 2 Married 1 Yes If Yes, Give 2**X** No Saltimore, Maryland 21215-0036 1 Yes 2 No Specify. Specify: White "natural", 3 X Widowed 4 ☐ Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) than, Elementary/Secondary (0-12) College (1-4 or 5+) Retail Store Department Manager should be filed with and Mental Hygien 7 is marked other th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Bonnie Alexander Melvin Todd injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Department of Health ar Important: If item 27 is any injury or are 3417 Swallowtail Court, Edgewater, MD 21037 Gloria Catevenis / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. | 03/22/2012 Baltimore, Maryland 22. Name and Address of Facility Cremation Society of Maryland Inc 21. Signature of Funeral Service Licensee Alyson K Taylor 299 Frederick Road, Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final h sician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events and Due to (or as a consequence of): resulting in death) Last burial physician Physician/Medical P.O. Box 68760 the IF FEMALE nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death signed by the a Unknown g Unknown ant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsv After this certificate has 1 ☐ Yes 2 ☐ No Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical filled in by the funeral director, 26. Place of Death (Check only one) Be examiner? Hospital 2-No 1 🗌 Yes ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 1 Natural 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) iniury 5 Pending work? 1 ☐ Yes 2 ☐ No s after death. М 2 Accident
3 Suicide
4 Homicide Accident Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 24 hours after d Funeral Direct determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 Signature and title of cer 29c. License number of death (Item 23a) (Type, Print) Name and address of pers APOLIS MD2144 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 12:20 14 2012 0 MARCH /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE HOSPITAL HGNES Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Min. 1 M 2 0 F Yrs. **Director** Manyland Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 28a-f show ed other than "natural", or items 23a or 28a-f shovevent, the Medical Examine must be retilied at 1 Yes 2 No Director lt, mor Manyand 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Initec 2122 Funeral Juenue 12. Was Decedent Ever in U.S.
Armed Forces?
1 □ Yes 2 No
If Yes, Give
Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Asian Asian Specify: Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) T 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 1)NKNOWN ပ္ injury or other traumatic and I 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 20b. Place of Disposition (Name of cemetery, crematory or other place) Department of Health Important: If Item 27 NGUN KHING MOTHER Manylon 20c. Location - City or Town, State Date 20a. Method of Disposition Pages 1 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MAY 04, BALTIMORE, 2012 MARYLAND 22. Name and Address of Facility SAINT AGNES HOSE 900 S. CATON AVENUE BALTIMORE, MARYLAND 21229 21. Signature of Funeral Service Licenses HOSPITAL usandyn Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) prematur /Medical Due to (or as a confequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter or carrying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) P.O. Box 68760, ed by the attending physician detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performe 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Wother (Specify) & What 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 ☐ Yes 2 ☐ No after death 2 Accident filled in by the 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. the To the within 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Caton Garner MO Avenue 900

DHMH 17 Rev 1/2001

State Registrar 37. Registrar's Signature

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		-	For State Registrar		State	of Mar	yland	d / Depa <i>Cer</i>	artment <i>tificate</i>	of E	ieaith Death	and N	iental Hy	/gien Reg. N	-	12	0909	
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03	ırs aft ural", I Exar	ted t	3 🗌 Widowed	4X Divorced	If Yes, Gi Year or D	ve			∣ ☐ Yes 2	X No	Specif	y:			Specify:	W	HITE	
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Baltimore,	permit. Page Department of Important; If any injury or once.		21. Signature of Fu	neral Service	2			100	. Name and				L LEVI					
	ED = 60	Н	8900 REISTERSTOWN ROAD, PIKESVILL 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,												LE, I	Approximate	-	
	Physician/		shock, or hea Immediate Cause	rt failure. List o (Final	only one cause on e	ach line.								,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			Interval Between Onset and Death	
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rds	require	etec			ER, CH								24a. Wa:				psy findings available	
Seco	sician: The law i certificate has k lirector, page 2 s	Completed by	PULMO	MARY	DISEASE	, -	M 1-1	172F	MIŦ				aut	opsy formed?	, F	orior to co death?	impletion of cause of	
al H	an; Th	Be C	25. Was case refer	red to medical						26. Pla	ace of De	eath (Checi	1 \(\sum \) Yes (only one)	2 🗷	No	Yes	2 No	
Zi.	Physician: this certific ral director,	유		¥No					nt 3 🗆 DO/								HOSPICE	
Division of Vital Records,	ding h. After fune	Certificate:	27. Manner of Deat 1 Natural 2 Accident	5 Pendir	ng (Mo	e of injury nth, Day, \		28b. Time of injury	M 28	c. Injury work	/at ? Yes 2[28d. Describe	how inj	ury occurre	ed		
isio	Attencer death	rtifi	3 Suicide 4 Homicide	Investi 6 Could determ	not be 28e. Plac	e of Injury		ne, farm, str	eet, factory,							er or Rura	l Route Number,	_
Ω̈́	Hospital or 24 hours afte Funeral Dir stely filled in				0								City or To					
	Hospital or Atten 24 hours after deat Funeral Director; etely filled in by the	Medical	(Check 2	2 Medical I		asis of exai	mination	and/or inves	tigation, in m	y opinic	on, death	occurred a	the time, date	and pla	ce, and due	to the ca	ause(s) and manner sta	ated.
	To the Hosp within 24 ho To the Fune completely f	Σ	29b. Signature and	title of certifie		er: to the b	est of my	y knowleage			number		ice, and due to		Date signed			_
			Gom	now,	4BBS				F	RES	-0	00		M	ARCH	1,20	1,2012	
	10 M		30. Name and add															
			GRUZA 31. Date filed (Mon		AUDI-IAF	Registrar's			SPITI	FL	OF I	BALT	IMOR	E				_
	Sta Registr			000		- Cylotiai s	A	bas	Land .									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2012 090												
	Physicia		Decedent's Name (First, Middle, L DOROTHY F. LANO	· ·		inouto or B	- Cutt	2. Date of De		3. Time of Death 7:45A. M			
	Medic Examir		4a. Facility Name (if not institution, g	ive street and number)		4b. City, Town, or TIMONI			4c. County of Dea				
	Funeral Director		5. Social Security Number 217–20–8609 Usual Residence of Decedent	. Sex 7. Age (In yrs. 1 ☐ M 2 🗶 F 82	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da 8-31-1	iy, Year) C	rthplace (State or Foreign ountry) ARYLAND			
	Maryland 8a-f show tified at	Funeral Director	10a. State 10b. County	BALTO.	ity, Town or Loc	ation NOTTINGHA	ıM.		•	10d. Inside City Limits 1 ☐ Yes 2 🛣 No			
	th the N 3a or 2 t be no	al Di	10e, Street and Number			10f. Zip Code			10g. Citizen of What C	ountry?			
	ath wif	nner	8604 COTTINGTON	ROAD 12. Was Decedent Ever in U	S 13 V	21236		or No	14. Race - Am				
□	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	1 Never Married 2 Marrie 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates.	1	/as Decedent of His Yes, specify Cubar	Specify:	Rican, etc.)	Diadity Title				
:45 a.m.	ithin 72 ho ene. • than "na"	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)		(Give k	ent's Usual Occupa ind of work done du ONOT use retired) TITUTE TE	uring most of work	ing	16b. Kind of Business BALTIMORI				
7	2 should be filed with and Mental Hygis 27 is marked other traumatic event, t	Maiden Surname)											
2012	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State												
	1 and 2 sh of Health ar item 27 is		ARTHUR LANOCKA 20a. Method of Disposition	SPOUSE	Place of Dispos			D NOTTI	NGHAM, MD. 20c. Location - City of				
ARCH 18,	age 1		1 Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spe	Removal from State	cemetery, crem	or or other place	9)	-2012	BALTO.MD.	i iowii, State			
MARCH	partit. F Departm Importa any inju		21. Sign ture of Funeral Service Lic	1 02		Name and Address				RAL HOME, INC			
MA	1 20 E 8 9		Difance	Rueke		6415 BELA			. MD.21206				
	Phylician Medical Examiner		23a. Part 1. Enter the disease, or conshock, or heart failure. List onlimmediate Cause (Final disease or condition resulting in death)	y one cause on each line. CEREBROVAS(Due to (or as a consec	CULAR A	- Carrier Co	g, such as cardiac (n respiratory ar		Approximate Interval Between Onset and Death			
	ted nsit	ıminer	Sequentially list conditions, if any, leading to immediate cause E for Uncerly! g Cause (Disease or Injury	b. Due to (or as a consec	quence of):								
Ç	te be executed hysician and the burial-transit	ical Exa	that initiated events resulting in death) Last	CDue to (or as a consec	quence of):	-		-					
	tificate ng phy	Med	IF FEMALE:	10									
Dox 607	. e + 5	Physician/Medical Examiner	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 🛣 No 9 ☐ Unknown	23c. If yes, outcome of pregn 1 Live Birth 2 Fe 4 Pregnant at time of 9 Unknown	tal death 3 🗌	Ectopic pregnancy Other (specify)	У		23d. Date of d Month	elivery Day Year			
LANOCKA	quires that t en signed b	ted by P	Part II. Other significant conditions	s contributing to death but not re	sulting in the u	nderlying cause give	en in Part I.	1	obacco use contribute t	. /			
	The law re cate has be r, page 2 sh	Completed by						1 🗌 Yes	psy prior to ormed? prior to	utopsy findings available completion of cause of es 2 🛣 No			
DOROTHY	sician sicertif	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ▼ No	Hospital:	TER/Outpotion	Othe	r:		dence 6 🗶 Other (Spe	cify) HOSPICE			
	nding Phy ath. :: After this	icate: T	27. Manner of Death 1 Natural 5 Pending 2 Accident Investiga	28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injury work?	at		now injury occurred	RUSPICE			
	cal or Atte	l Certificate:	3 Suicide 6 Could no 4 Homicide determin		ome, farm, stre	et, factory, office		28f. Location (City or Tox	Street and Number or Rivn, State)	ural Route Number,			
	the Hospii nin 24 hour the Funera	Medical	(Check 2 Medical Exaconly one) 3 X Certifying N	hysician: To the best of my know aminer: On the basis of examination lurse Practitioner: To the best of	on and/or invest	gation, in my opinior death occurred at th	n, death occurred at ne time, date and pla	the time, date a	and place, and due to the	cause(s) and manner stated.			
	10 en		29b. Signature and title of certifier	1 DNP, NP		29c. License	number 0276	2	3 19	th, Day, Year) 20/2			
7	(O.D.		30. Name and address of person with TRACIE L. MORG	AN, CRNP 2300		rint) VALLEY	RD. TTM	MITING	MD 21093				
7	Sta Registr		31. Date filed (Month, Day, Year) NAR 2 3	32. Pegistrar's Signa		Wed							

DHMH 17 Rev 06-2011

MARCH 18, 2012 7:45 a.m.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ March Robert Carl Lindstrom 18, 2012 7:05 PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 18000 Cashell Road Rockville Montgomery If Under 1 Year | If Under 24 Hrs Social Security Number 7. Age (In yrs. last birthday 8. Date of Birth g. Birthplace (State or Foreign Funeral Days December 19 1929 New York 132-20-1946 1 🛛 M 2 🗆 F Months **Director** 82 Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🗓 No Maryland Montgomery Rockville 10e. Street and Number 10g. Citizen of What Country? Funeral 18000 Cashell Road 20853 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?
1 X Yes 2 □ No 1947-Black, White, etc. ģ 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 1967 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) National 4-H College (1-4 or 5+) Elementary/Seconday (0-12) Director Center permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked othe any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Otto Carl Lindstrom Tyra Fagerholm 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda Lindstrom / Wife 18000 Cashell Road, Rockville, Maryland 20853 Baltimore, 20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) unk. Date 20c. Location - City or Town, State Arlington National Cemetery Arlington, Virginia 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License ROLL Name and Address of Facility Rollert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 M01305 7557 Wisconsin Avenue, Bethesda, Ma Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Aspiration Pneumonia disease or condition resulting in death) **Medical** Due to (or as a consequence of) Examiner Stroke Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): death certificate be executed burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 nding phys use as the 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year Pregnant at time of death 5 Other (specify) Month g Unknown g Unknown To the Hospital or Attending Physician; The law requires that the within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has l autopsy performed? Yes 2 No 1 Yes 2 No **Division of Vital** 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 Yes 2 X No မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at within 24 hours after death.

To the Funeral Director: After completed filled in by the funeral 5 Pending 1 Tes 2 No 2 Accident Investigation Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 🔼 certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Gertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

State Registrar 29b. Signature and tille of certifier

31. Date filed (Month, Day, Year) NAR 2 3 2012

Lynn Byars,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

MD 8901 Wisconsin Avenue, Bethesda, Maryland 20889

VA-0101240414

29d. Date signed (Month, Day, Year)

March 20, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ March 20 2012 Medical 4a. Facility Name (if a institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Randallstown Seasons Hospice If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 217-52-8112 Director 1 M 2 K F March 7, 1950 62 Maryland Usual Residence of Dece 28a-f shov 10a. State 10c. City, Town or Location 10d. Inside City Limits the Maryland aţ Director ems 23a or 28a-f sh r must be notified a MD Baltimore 1 🗌 Yes 2 😾 No Catonsville 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 1125 Pleasant Valley Drive 21228 USA death 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Examiner Black, White, etc. White or Ş 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after 1 Yes 2 No Specify: Specify. "natural", Completed 3 Widowed 4 Divorced the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) of Health and Mental Hygiene. item 27 is marked other than other traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) Clerk Insurance Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Ellen Nolan Joseph F. Langan, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau Eileen Rodberg 6722 Summer Rambo Court; Columbia, MD 21045 Sister 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🗷 Burial 2 🗌 Cremation 3 🗆 Removal from State New Cathedral Cemetery 3/24/2012 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 21. Signature of Funeral Service 02010M 630 Edmondson Avenue: Catonsville 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Phylician disease or condition resulting in death) pheumoni Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last burial-transi and Due to (or as a consequence of): attending physician I for use as the buria Physician/Medical • Hospital or Attending Physician: The law requires that the death certificate be 124 hours after death.
• Funeral Director: After this certificate has been signed by the attending physicia Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Year Month Day Pregnant at time of death ed by the al detached f 9 Unknown been signed by should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performe 1 Yes 2 🗌 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence ဂ္ဂ 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Natural iniury 5 Pending Investigation Accident filled in by the 6 🗆 Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 🕰 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one

29b. Signature and title of certifi

Registrar DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month March 1 7 ay 20°1°2 2:00 PM Whitney French Morrill /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Manor Care Ruxton Towson Baltimore If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, July 11, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 XM 2 ☐ F 212-28-2044 87 Director 1924 New York, NY Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

Int: If Item 27 Is marked other than "natural", or items 23a or 28a-f show 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Evaminar must be notified at Baltimore MD Park ton **Funeral Director** 1 ☐ Yes 2√☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2001 Harris Mill Road 21120 United States 12. Was Decedent Ever in U.S. Armed Forces? 1X Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Completed by 1 ☐ Yes 2 ☐ No Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Heam, Morrill + Co Elementary/Secondary (0-12) College (1-4or 5+) Partner 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Frank Whitney Morrill Evelyn Walker 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frank Morrill, II -Son 2001 Harris Mill Road Parkton, Maryland 21120 20b. Place of Disposition (Name of Stemplery, crematory or other place) 20a. Method of Disposition March Date 24. 20c. Location - City or Town, State permit. Pages Department of Important: If It any injury or o X Burial 2 ☐ Cremation 3 ☐ Removal from State Monkton, 4 ☐ Donation 5 ☐ Other (Specify) Church Cemetery 2012 22. Name and Address of Facility
Evans Funeral Chapel & Crematic
16924 York Road Markton, Maryla
23a. Part 1. Enter the disease, or complications that caused the death. Shock, or hear fallure. List only one cause on each line.

Immediate Cause in all disease or conditions. 22. Name and Address of Facility
Evans Funeral Chapel & Cremation Services
16924 York Road Monkton, Maryland 21111 Approximate Interval Between Onset and Death Physician En. Stuge disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) P.O. Box 68760, C. burial-trai Due to (or as a consequence of) physician or Attending Physician; The law requires that the death certificate be Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month Dav Year 5 Other (specify) 2 No ed by the 9 Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death2 Division of Vital Records, þ 4 Unknown 2 No 3 Probably 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has this certificate 2 **1**No 1 ☐ Yes 2 CHNC 1 ☐ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Wursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 27. Man or of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation after death the 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital c within 24 hours af To the Funeral Di 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number

Phy hr

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MO

32. Refistrar's Signature

HIRPARA

MAR 2

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Reg. No. 2 edent's Name (First, Middle, Last 2. Date of Death 3. Time of Death Physician/ 2012 8:06 A M arch Medical 4a. Facility N me (if not institution Examiner Town, or Location of Deatl wings Mills voods Raltimore Dummer 9. Birthplace (State or Foreign Country) Social Security Number # 5 **Funeral** in yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 58 1 M 2 VI Months **Director** Usual Residence of Decedent 28a-f show should be filed within 72 hours after death with the Maryland and Mental Hyglene. is marked other than "natural", or items 23a or 28a-f shov er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a. State 10b. County 10d. Inside City Limits Director Baltimore 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21117 **ಎ**೦೩ ummer Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U Armed Forces? 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married ģ 2 No Baltimore, Maryland 21215-0036 Yes If Yes, Give Year or Dates 1 Yes 2 No Specify 3 ₩idowed 4 Divorced Completed lac 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) day (0-12) College (1-4 or 5+) trtis t Be injury or other traumatic event. 17. Father's Name (First, Middle, Last) r's Name (First, Midele, Maiden Surname) permit. Page 1 and 2 should be Department of Health and Menta Important: If item 27 is marken any injury exercise. ပ 19b. Mailing Address (Street an latKins Jumme 20a. Method of Disposition Place of Disposition (Name of 20c. Lo 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) hadres of Gillityeene 229) Nationa 23a. Part 1. Enter ne disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or head ailure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph_sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to (or as a consequence of): burial-transit and Due to (or as a consequence of): attending physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the use as IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No Pregnant at time of death Month Day Year signed by the a Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 Yes 2 No 3 Probably 4 WUnknown Completed should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page 2 s After this certificate has performe 1 Yes 2 No 25. Was case referred medica examiner? funeral director, 26. Place of Death (Check only one) Be Hospital 2 No Other: မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural injury 5 Pending work? 1 🔲 Yes death. 2 🗌 No Accident Investigation 2 Accider
3 Suicide within 24 hours after deat To the Funeral Director: 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide completed filled in by determined Medical 29a. Certifier Cyrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. dedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 32. Registrar's State MAR 2 3 2012

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Robert Year 2012 Month 02:58 A M J Minnick 16 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death University of Maryland Medical (enter Baltimore Baltimore City 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth Days Hours Min. (Month, Day, Year) 215-88-4682 1 ★ M 2 🗆 F 49 Apr. 12, 1962 Maryland Usual Residence of Deceder 10a. State 10c. City, Town or Location 10d. Inside City Limits Maryland Anne Arundel Linthicum 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21090 614 Brentwood Rd. United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Armed Forces? 1 Yes 2 No Black, White, etc. 1 Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2 🛛 No Specify: Specify: 3 Widowed 4 X Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Roofer Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Phyllis A. Layman Elmer Minnick 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brenda Minnick / Sister 3019 Louisiana Ave., Baltimore, MD 21227 20a. Method of Disposition 20b. Place of Disposition (Name of March 21, 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 K Cremation 3 Removal from State Catonsville, Maryland Metro Crematory, Inc. Donation 5 Other (Specify) 21. Signa o Puneral Se Kirkley-Ruddick Funeral Home, P.A. 421 Crain Hwy., S.E., Glen Burnie, MD 21061 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Ventricular Tachicardia disease or condition resulting in death) 7 days Muccardial Inforction Sequentially list conditions Due to (or as a consequence of): If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Entercoccus faecalis bacteremia Due to (or as a consequence of): resulting in death) Last IE FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Year Month Day Pregnant at time of death Yes 2 No 9 Unknown g Unknown

Ph_sician/ Medical **Examiner** Examir Hospital or Attending Physician: The law requires that the death certificate be executed -tran

Physician/

Medical

Examiner

Funeral

Director

28a-f shov

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"natural", or items 23a o

traumatic event, the Medical

and Mental Hygiene. is marked other than

Department of Health a Important: If item 27 is any injury or other tra

hours after death

Baltimore, Maryland 21215-0036

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Director

Funeral

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burial Physician/Medical the attending p signed by the at ρ Completed page 2 s Be မှ ours after death. leral Director: After this filled in by the funeral d Certificate:

Medical

only one)

31. Date filed (Month

29b. Signature and the of certifier

has

Part II. Other significant conditions o	contributing to death but not re	sulting in the underlying	g cause given in Part I.		se contribute to the cause of death?		
				24a. Was an autopsy performed? 1 \sum Yes 2 \sum No	24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No		
25. Was case referred to medical			26. Place of Death (Che	ck only one)			
examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3 🗌	lome 5 Residence 6	me 5 Residence 6 Other (Specify)			
27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident Investigatio		28b. Time of injury M	28c. Injury at work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury	occurred		
3 ☐ Suicide 6 ☐ Could not be determined	1 280 Place of Injuny - At he		28f. Location (Street and City or Town, State)	Number or Rural Route Number,			
29a. Certifier 1 Certifying Phy (Check 2 Medical Exam	sician: To the best of my know liner: On the basis of examination	rledge, death occurred in and/or investigation, i	at the time, date and place, n my opinion, death occurred	and due to the cause(s) an at the time, date and place,	d manner as stated. and due to the cause(s) and manner stated.		

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

1275822876

Battimore, MD

29d. Date signed (Month. Day. Year)

03/16/2012

21201

To the within 2

Division of Vital Records, P.O. Box 68760

30. Name and address of person who completed cause of centh (Item 23a) (Type, Print) 22 South Filipa

Ligeiro, MD Greene 32. Registrar's Signature

State Registrar

completely

MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

			For State		State	of Mary	rland / Depa				and M			0010		0101
	-		Registrar 1. Decedent's Name (F	irst. Middle. I	_ast)		Cei	tificate	e or L	eatn	Т	2. Date of Dea	Reg. N ath	0. / /	3 Tim	e of Death
-	Physicia		WILLIAM			1G						MARCH		2012 Year		45P M
-	Medic Examin		4a. Facility Name (if no	t institution, g	ive street and nur	mber)		4b. City,	Town, or	Location o	of Death			c. County of Death		
			STELLA MA					1611	4.10	TIMO					LTO.	
	Funeral Director		5. Social Security Num 202-03-548		. Sex 1 🛣 M 2 □ F	7. Age (In	ge (In yrs, last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.					8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Forei Country)				
		. 1	Usual Residence of D		X		90 Yrs.					10-27-	192	1 PENN	SYLVA	
	yland f sho ed at	ctor		Ob. County	T TO	100	c. City, Town or Lo	cation ARKVI	מווד							e City Limits
	e Mar r 28a- notifi	Dire	MD 10e. Street and Number		LTO.		1	10f. Zip		_			100.0	itizen of What Co		Yes 2 X No
	vith th	Funeral Director	8810 WALT		VD IINT	г 2103	1	101. 219	212	234			rog. C	USA	aritiy:	
	eath v	Fune	11. Marital Status	ILEK DI	12. Was Dec Armed Fo	edent Ever	in U.S. 13. 1	Nas Deced f Yes, spec	lent of His	spanic Orig	gin? (Spec	cify Yes or No-		14. Race - Amer		,
в. 36	after d I", or i camin	by	1 Never Married		d 1 Yes	2 No		Yes				iican, etc./		Black, White Specify: W	, etc. HITE	
1:45 p.m. 21215-0036	atura cal Ex	Completed	3 X Widowed 4	Divorced 15. Decedent'		ates. 194	43-1947 16a. Dece	dent's Usua	al Occupa	ation			16h	Kind of Business/l	ndustry	
:45 1215	in 72 h e. ian "n Medi	duc	(Specify Elementary/Second		grade completed		(Give	kind of wor O NOT use	rk done di	uring mosi	t of workin	ng .				
11:	d withi ygien yer th	Be Co	11TH_				INSU	IRANCI	E EXI					SURANCE	COMPA	NY
n o	se filed set of ced of	To B	17. Father's Name (First	st, Middle, Las	st)						er's Name .ULINI	(First, Middle, F. IJNK	Maider NOW	,		
2012 Aaryla	nd Me s mark	VS	UNKNOWN 19a. Informant's Name	e/Relationship	(Type, Print)		19b. Mailii	ng Address	(Street a	_			r, City c	or Town, State, Zip	Code)	
	id 2 sh ealth a n 27 is er trau		ROBERT P.	MEIST	CERING	S	ON	9315	5 RAN	4BLEB	ROOK	ROAD	NO	TTINGHAM	, MD.	21236
fARCH 16, Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Dispos		☐ Removal from	n State	20b. Place of Dispo cemetery, cres	natory`or o	ther place	e)		ate		Location - City or		
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MARCH Baltin	permil Depar Impor any in once,	Į,	21. Sign ture of Funer	al Service Lig	ensee	>	2	2. Name an 97 (ELAIR	, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			GHAM, MD		Contraction of the Contraction o
		_	23a. Part 1. Enter the shock, or heart for	disease, or o	omplications that	caused the	death. Do not ent	er the mode	e of dying	g, such as	cardiac or	respiratory and	rest,		Approx	mate Between
	Ply i jan		Immediate Cause (Fir disease or condition				ASCULAR .	ACCID	ENT							nd Death
	Medical Examiner		resulting in death)	6			nsequence of):									
		ıer	Sequentially list cond if any, leading to imm	itions,	b. — Due to	(or as a co	nsequence of):									_
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ch	ate be executed physician and the burial-transit	EX	that initiated events resulting in death) Las	st	Due to	(or as a co	nsequence of):									
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TER 687	sertific ading p	M/M	IF FEMALE: 23b. Was decedent pro	egnant	23c. If yes, ou	itcome of p	regnancy							23d. Date of del	verv	
31S 30X	eath of atter	icia	in the past 12 mo	nths?	4 🗌 Pre	gnant at tim		☐ Ectopic p☐ Other (sp		у				Month	Day	Year
WILLIAM MEISTER cords, P.O. Box 687	t the c by the	by Physician/Me	9 Unknown Part II. Other significa		9 Unk		at requiting in the	and orlying	naugo giv	on in Bort		00. Did.			th	of doath?
IAY P.	es tha signed I be de	l by	Part II. Other significa	int condition	s contributing to	deam but m	or resulting in the t	inderlying t	cause giv	elilirati	1.			use contribute to		
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WILLI Division of Vital Records,	ne law e has age 2	Completed										autor	psy ormed?	death?	ompletion 2 2 00	of cause of
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n of	ding P h. After t funera	ate:		5 Pending		e of injury nth, Day, Ye	ear) 28b. Time o injury	M 2	8c. Injury! work!	rat ? Yes 2□		8d. Describe h	now inju	iry occurred		
isio	Atten er deat ector: by the	Certificate:	2 Accident 3 Suicide 4 Homicide	Investiga 6 Could no determin	ot be 28e. Plac	e of Injury -	At home, farm, str							nd Number or Rui	al Route N	umber,
Div	ital or irs afte al Dire				bullo	ding, etc. (S)	Decity)					City or Tov	vn, Stat	'e)		
	To the Hospital or Attending Physician: The law requires that the death certifics within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as:	Medical	29a. Certifier 1 (Check 2)	Medical Ex	aminer: On the ba	asis of exam	knowledge, death ination and/or inves	tigation, in	my opinio	n, death or	ccurred at	the time, date a	and plac	ce, and due to the o	ause(s) and	d manner stated.
	Fo the within To the comple	Σ	only one) 3 L2 29b. Signature and titl		lurse Practitione	er: 10 the be	st of my knowledge		License		ite and pla	ce, and due to t		se(s) and manner a)
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	1 0		TRACIE L 31. Date filed (Month,	Day, Year)	32.	Redistrar's	O DULANE Signature			RD.	TIMO	NIUM, N	<u>MD 2</u>	21093		-
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DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #17&18 Per FH G925 3/27/2012 IIII State of Maryland 7 Department of Health and Mental Hygiene State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year Physician/ 35 AM march 201 Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death **Examiner** BALTO. NOTTINGHAM 28 FOX BRIER LANE If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday, Social Security Number 6. Sex **Funeral** Days Hours 1-13-1925 NORTH CAROLINA 1 M 2 XF Months 87 Director 220-14-2712 Usual Residence of Decedent 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Martal Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner. 10c. City, Town or Location 10b. County 10a. State should be filed within 72 hours after death with the Maryland Director NOTTINGHAM BALTO. MD. 1 Yes 2 No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral USA 21236 28 FOX BRIER LANE Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married b Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Specify: BLACK Yes, Give 3 XWidowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) US POSTAL SERVICE SORTER Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Lat.

Thomas

HARVEY NORMAN er's Name (First, Middle, Last) BETTY HARDEN Betty Lou Haevey Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 28 FOX BRIER LANE NOTTINGHAM, MD. 21236 19a. Informant's Name/Relationship (Type, Print) 28 FOX BRIER LANE DTR. JOSEPHINE CORNICK 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) EMPORIA, VA. FAMILY CEMETERY 3-25-2012 MYRTCK 22, Name and Address of Facility SCHIMUNEK FUNERAL HOME, INC. 21. Signature of F meral Se NOTTINGHAM, MD. 21236 9705 BELAIR ROAD Rart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final One Pnysician MP disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): Exami attending physician and for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical that the death certificate be P.O. Box 68760 IF FFMALE: 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ____ Live Birth 2 Fetal death Year Day Month in the past 12 Pregnant at time of death Yes 2 X No been signed by the should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Division of Vital Records, within 24 hours after death.

To the Funeral Director: After this certificate has been significate filled in by the funeral director, page 2 should to completed filled in by the funeral director, page 2 should to 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes To the Hospital or Attending Physician: The Sarah 26. Place of Death (Check only one) 25. Was case referred to medical Certificate; To Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of 28c. Injury at work? 27. Manner of Death 28a. Date of injury 28d. Describe how injury occurred (Month, Day, Year) injury 5 Pending 1 X Natural 1 ☐ Yes 2 ☐ No Investigation Accident 3 Suicide
4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆 only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier who completed cause of death, Item 2 ona Lane#216 M.D. 32 egistrar's Signatur 31. Date filed (Month State

DHMH 17 Rev 7/2009

Registrar

Myrick

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** March 2012 Helen Myers Mae /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** VERSI L CAM 1E 8. Date of Birth (Month, Day, Year) If Under 24 H If Under Year 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Months Hours Min 1 □ M 2 F Yrs. 91 06/11/1920 Maryland Director 220-07-6227 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County show Health and Mental Hygiene. em 27 Is marked other than "natural", or items 23a or 28a-f shov ither traumatic event, Its Medical Examiner must be rigitled at 1 ☐Yes 2 XNo Director Maryland Baltimore White Marsh the 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number death with 21162 U.S.A. 11240 Philadelphia Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2XNo If Yes, Give Year or Dates Specify. þ White 3 Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Aircraft Defense Elementary/Secondary (0-12) 10 College (1-4or 5+) Contractor Clerk 18. Mother's Name (First, Middle, Maiden Surname) 17, Father's Name (First, Middle, Last) Be Laura Friddle John Bowman ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 11240 Philadelphia Road, White Marsh, Md. 21162 Department of Health Important: If Item 27 any Injury or other to once. Earl Myers (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Holly Hill Mem. Gard 03/24/2012 | Baltimore, Maryland 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Bruzdzinski Funeral Home, P.A. 21. Signature of Funeral Service Licenses 1407 Old Eastern Avenue, Essex, Maryland 21221 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final discrete or condition resulting in death) **Physician** CONTOLLE /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine e Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. e-e Funeral Director: After this certificate has been signed by the aftending physician and leitely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year Day 5 ☐ Other (specify) 1 ☐Yes 2 ☐ No 9 Unknown 9 Unknown nis certificate has been signed by director, page 2 should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 \(\text{Yes} \) 2 \(\text{No} \) 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury 28c. Injury at Work? 27. Manner of Death (Month, Day, Year) Injury 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide determined 4 Homicide 1 Ccertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 24 ho

To the Fune

completely f 29d. Date signed (Month, Day, Year) 29c. License numbe 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year)

MAR 2 3 2012

lo V

32. Registrar's Signature

Sake

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) 3. Time of Death Day 2012 March 18, Physician/ 5:10 \mathbf{P}^{M} Lillian Whitley Magruder Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Rockville Montgomery Rockville Nursing Home Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In yrs. last birthday **Funeral** Days Hours 244-12-8066 **Director** 1 □ M 2 🗓 F 90 October 12, 1921 North Carolina 10d. Inside City Limits 28a-f show 10c. City, Town or Location 10a. State 10b. County with the Maryland Funeral Director notified 1 Yes 2 No Rockville Maryland Montgomery 10g. Citizen of What Country? 10e Street and Number ö be 23a 20851 United States 1712 Crawford Drive permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: If Yes, Give Year or Dates Specify: White 3 X Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Federal Government Secretary Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Nancy Mitchell James M. Whitley 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 15221 Apricot Lane, North Potomac, Maryland 20878 James W. Magruder, Jr. /Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition ${\tt March}^{\tt Date}$ 20c. Location - City or Town, State 24, 1 X Burial 2 Cremation 3 Removal from State Rockville, Maryland Parklawn Memorial Park 2012 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Robert A. Pumphrey Funeral Home/Rockville, Inc. ette Onsis 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 M01305 Part 1. Enjer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 23a. Part 1. Immediate Cause (Final disease or condition Physician/ Hypertensive Heart Disease Medical resulting in death) Due to (or as a consequence of): **Examiner** Chronic Obstructive Pulmonary Disease Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of). Cause (Disease or injury that initiated events resulting in death) Last Dementia and Due to (or as a consequence of) attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Septicemia Division of Vital Records, P.O. Box 68760 IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death 3 Ectopic pregnancy Day Month Year in the past 12 months? Pregnant at time of death 5 Other (specify) Yes 2 X No g | Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform 1 Yes this certificate Yes filled in by the funeral director, 26. Place of Death (Check only one) Be 25. Was case referred to medica examiner? Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) မ 28b. Time of Certificate: 27. Manner of Death 28a. Date of injury 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) injury 5 Pending 1 Tes 2 No 2 Accident
3 Suicide
4 Homicide Investigation within 24 hours after deat To the Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated the only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number NUMBO March 19, 2012 D0047330

State Registrar

(1)

Thomas V. Joseph, M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Momus

50 West Edmonston Drive, Rockville, Maryland 20852

Baltimore, Maryland 21215-0036

P.O.

Records,

of Vital

Division

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 03 2012 19 CHRISTINE MOSLEY 0746 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death BON SECOURS HOSPITAL BALTIMORE 7. Age (In yrs. last birthday) Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Hours (Month, Day, Year) **Director** 21708804815 47 1 M 2X F Yrs 06-29-1963 MARYLAND Usual Residence of Decede 28a-f show 10a. State 10b. County 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director 1 X Yes 2 No MD BALTIMORE 23a or 2 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5312 NELSON AVE. U.S.A. items Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 🔀 No 10 · Black, White, etc. Completed by 1 Never Married 2 Married filed within 72 hours after 1 ☐ Yes 2 🗓 No Specify: If Yes, Give "natural" Specify: 3 Widowed 4 X Divorced **BLACK** Year or Dates traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) marked other than should be filed within and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) 10 PACKER FOOD SERVICES 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) JAMES A. MOSLEY CHRISTINE SHAW 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) S t. Page 1 and 2 street of Health a item 27 STELLA MOSLEY-SISTER 5312 NELSON AVE. BALTIMORE, MD 21215 or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite cemetery, crematory or other place, 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Deher (Specify) METRO CREMATORY 03/20/2012 BALTIMORE, MD 21. Signature of Funeral Service Acende VILLIAM C. BROWN COMMUNITY FUNERAL HOME P.A. 206 W. NORTH AVE. BALTIMORE, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death >FASI'S Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner NEUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner as a consequence of Cause (Disease or injury that initiated events resulting in death) Last that the death certificate be executed Due to (or as a consequence of): the burial-Physician/Medical CESPIRATORY FAILURE IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? 4 ☐ Pregnant at time of death 9 ☐ Unknown signed by the at the detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed SEIZURE DISORDER Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy CVA Yes Hospital or Attending Physician: 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) 1 Yes Other: 2 No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation Could not be filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check To the P within 2. To the F only one) Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title 29d. Date signed (Month, Day, Year) 070720 M.D. eted cause of death (Item 23a) (Type, Print) 2000 W. BALTIMORE ST. BALTIMORE, MD. SIDDIAM 31. Date filed (Month State Registrar

State of Maryland / Department of Health and Mental Hygiene 2 1 2 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2012 Physician/ Patricia Ann Van Newkirk March 22 04:30 AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 4102 Dee Jay Drive Ellicott City Howard 8. Date of Birth
(Month, Day, Year)
Apr 23, 1937 If Under 1 Year If Under 24 Hrs **Funeral** Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Rep. of Panama **Director** 216-34-5828 1 M 2 X F 74 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27.5 is marked other than "natural", or items 23a or 28a-f sho amy ritury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Howard Ellicott City 1 Yes 2 XNo 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 4102 Dee Jay Drive 21042 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 XMarried þ 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Joseph Henry Stilson Anna Catherine Dybbro . Page 1 and 2 should ment of Health and M tant: If item 27 is mar 19a. Informant's Name/Relationship (Type, Pnint) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carl D. Van Newkirk/husband 4102 Dee Jay Drive Ellicott City, MD 21042 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Journey Crematory 03/22/12 Woodbine, MD Signature of Funeral Service Licenses 22. Name and Address of Facility Coing Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or conditi resulting in death) Chronic Obstructive Pulmonary Disease vears Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): burial-Physician/Medical death certificate be Box 68760 the as use 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery atter for u 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? 1 ☐ Yes 2 X No Month Day Year P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Completed 1 X Yes 2 □ No 3 □ Probably 4 □ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 2 X No or Attending Physician: 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) 1 ☐ Yes 2 🔀 No Other: ည 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 X Residence 6 Other (Specify, 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1X Natural 5 Pending n 24 hours after death.

e Funeral Director: After the function by the function of the functin work 1 Yes 2 🗌 No Accident Investigation Could not be 2 Accident
3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Sectifying Murse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 3 29b. Signature and title of certifie 29c. License numbe 29d. Date signed (Month, Day, Year) D50776 March 22, 2012 30. Name and address of npleted cause of death (Item 23a) (Type, Print) Steven H. Eversley, M.D. Suite 201 Ellicott City, MD 21042 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death March 21, Physician/ Margaret M. Nosek 9:54 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Timonium Stella Maris If Under 1 Year If Under 24 Hrs. Social Security Number 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Hours **Director** 220-03-8810 1 □ M 2XX F 92 Maryland March 16, 1920 Usual Residence of Deceden 28a-f shov I0a. State 10b. County 10d. Inside City Limits ortant. If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location with the Maryland Director Bel Air Harford 1 Yes 2 No Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? F.M. 21014 Funeral 709 East Farrow Court Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 Yes 2 X No White If Yes, Give Year or Dates 1 Yes 2 XNo Specify. Specify Completed 3 X Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumant. Elementary/Secondary (0-12) College (1-4 or 5+) Own Home 10 Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Delia Scally James Healev 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number of Ryral Route Number City of Town, State, Zip Code) 709 Fast Farrow Court Bel Air MD 21014 Thomas G. Nosek; Son 3altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 x Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Baltimore MD March 24, 2012 Holy Rosary Cemetery 4 Donation 5 Other (Specify) 3305 Hartond Road Baltimore M 21214 22. Name and Address of Facility Inc. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Exami Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician d for use as the buriz Physician/Medical death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy5 Other (specify) in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death been signed by the sahould be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has autopsy performed completely filled in by the funeral director, page 2 1 🗆 Yes 2 🗆 No Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? MARGARET Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ျ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 28d. Describe how injury occurred 1 Natural 5 Pending 2 🗌 No Accident Investigation 6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2300 DULANEY VALLEY ROAD 21093 JUSTINE PREIS, CRNP TIMONIUM

Registrar

State

31. Date filed (Monti

istrar's Signature

MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	State of Maryland / Department of Health and Mental Hygiene 1 - State															
			Registrar 1. Decedent's Name (First, Middle, Last)			Cen	incate	OID	eain		2. Date of De	Reg. No.	201	-	3. Time of	Death
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THE.	Medic Examin		4a. Facility Name (if not institution, give stre	et and number)			4b. City,				<u> </u>	4c.	County of E			
+			4601 N. Park Avenue						Chas				Mont	<u> </u>		
	Funeral Director		5. Social Security Number 6. Sex 217-46-8261	7. Ag€	e (In yrs. las		If Under Months	Days	If Under Hours	Min.	8. Date of Bir (Month, Da	ay, Year)		Countr		or Foreign
-			Usual Residence of Decedent	// 2 LJ F	65	Yrs.					June 1	3, 19	46 1		York	
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Maryland 21215-0036	uld be d Men marke natic	-	Edgar L. Newhouse, 19a. Informant's Name/Relationship (Type,			40h Maille	A al al	(Chun nh ni			I Route Numb		Taura State	Zin C	ada)	
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re,	of Health and Mental F of Health and Mental F fitem 27 is marked o r other traumatic eve		20a. Method of Disposition		20b. Pla	ace of Dispos metery, crem	sition (Nan	ne of	2)	Marc	n ^{2ate} 27,	20c. Lc	cation - Cit	y or To	wn, State	
<u>E</u>	Page 1 ment of ant: If it ury or o		1 X Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	moval from State		of Heav			ý	201		Silve	er Spri	ng,	Maryla	nd
Baltimore,	permit. Page Department Important: If any injury or once.	1 (3	21. Signature of Funeral Service Licensee	A M	101305	Rố 75	bert 4	d Address Consi	phrey n Aver	^{ty} Funei nue, E	ral Home Bethesda	/Bethe	esda-Ch Land 20	evy)814-	Chase, -3501	Inc.
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9	certificate be executed nding physician and use as the burial-transi	edical	d.													
89	requires that the death certifica been signed by the attending p should be detached for use as '	Physician/Me	IF FEMALE: 230. Was decedent pregnant 230	. If yes, outcome			l estado					- 1	23d. Date o	of delive	ery	
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<u>∑</u>	tal or as after al Dire		Tomode determined	building, et	c. (Specify)					2	City or 10	own, State				
_	To the Hospital or Attending Physician: The law requires that the death is within 24 hours after death. To the Funeral Director: After this certificate has been signed by the atter completely filled in by the funeral director, page 2 should be detached for	ledical	29a. Certifier 1	r: On the basis of e	examination	and/or invest	tigation, in	my opinio	n, death o	occurred a	t the time, date	and place	e, and due to	the cau	ise(s) and m	anner stated.
	To the within To the compl	Σ	29b. Signature and title of certifier	10-					number	- 1		29d. Da	te signed (A	Nonth, l	Day, Year)	
	10		I William G	my f	YL	ブ			DO	7147		Maı	cch 19	, 2	012	
	on		30. Name and address of person who con		death (Item	23a) (Type, F	Print)	02110	#71	00 0	Chevy C	hooo	Mort	71 on	d 208	15
	Cha	to	Allen A. Nimetz, I					enne	, 11/	, (nievy C	nase	, mar			
	Sta Registr		31. Date filed (Month, Day, Year) NAR 2 3 2012	32. Registr	A. 1	gara										

ndelible Ink. Ensure All Copies Are Legible, partment of Health and Mental Hygiene	0	9	10	9
partment of Health and Mental Hygiene	0	1	1 0	1

		1	For State Of Wal		rtificate of D			g. No.	
Н	Discolate	9,	1. Decedent's Name (First, Middle, Last)				2. Date of Death Month		3. Time of Death
	Physicia Medio	al	Luis Sotero	Ortega	Ortega .		March	1	2012 9:00 A M
A. S.	Examin	er	4a. Facility Name (if not institution, give street and number)			Location of Death		4c. County	
	Francis		Ingleside at King Farm 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Rockvi If Under 1 Year	11e If Under 24 Hrs.	8. Date of Birth	Mont	gomery 9. Birthplace (State or Foreign
	Funeral Director		0/0_3/_5629 1MM2DE		Months Days	Hours Min.	(Month, Day, \		Country)
	- MC		Usual Residence of Decedent	1			March 17	, 1931	Cuba
	yland -f sho ed at	ctor		Oc. City, Town or Lo					10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	r 28a notifi	Dire	Maryland Montgomery 10e. Street and Number	Rocky	7ille 10f. Zip Code		1/	0g. Citizen of W	
	vith th	ral	701 King Farm Blvd.		2085	0		_	States
	eath v tems er mu	Funeral Director	11. Marital Status 12. Was Decedent Eve	er in U.S. 13.	Was Decedent of His If Yes, specify Cubar		cify Yes or No-	14. Race	e - American Indian,
õ	fter d	by	1 Never Married 2 Married Armed Forces? 1 Yes 2 N If Yes, Give	D	If Yes, specify Cubar 1 Yes 2 No				k, White, etc.
ğ	e filed within 72 hours after death with the Maryland ttal Hyglene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Completed	3 ⚠ Widowed 4 □ Divorced Year or Dates.				ban	Specify:	White
5	72 ho n "na Aedio	nple	15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usual Occupa kind of work done d OO NOT use retired)		na	16b. Kind of Bu United	siness/Industry States
212	vithin jiene. er tha the N		Elementary/Secondary (0-12) College (1-4 or 5+)		hitect		1	Coast (
פַ	filed valued by the state of th	Be	17. Father's Name (First, Middle, Last)			18. Mother's Name	e (First, Middle, M	aiden Surname)
<u> a</u>	ld be Menta arked atic e	욘	Luis Ortega Verdes			Narcisa	Ortega		
Jar	2 should be file Ith and Mental I 27 is marked o traumatic eve	3	19a. Informant's Name/Relationship (Type, Print)	19b. Maili	ng Address (Street a	nd Number or Rura	l Route Number, (City or Town, S	tate, Zip Code)
e,	and tea thei		Narcisa Ortega Hickman/Daug	20b. Place of Dispo		-			City or Town, State
Baitimore, Maryland 21215-0036	permit. Page 1: Department of I Important: If it any injury or of once.		1 X Burial 2 ☐ Cremation 3 ☐ Removal from State	cemetery, cre	matory or other place aven Cemete	Marc Marc	h 23,		ring, Maryland
Ħ	nit. Paartme ortan injury		4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee			2 : 201			
Ř	Dep Imp any			1305 Re	obert A. Pun 557 Wisconsi	phrey Fune: In Avenue, 1	ral Home/E Bethesda, 1	Bethesda- Marvland	Chevy Chase, Inc. 20814-3501
			23a. Part 1. Ster the disease, or complications that caused the shock, or heart failure. List only one cause on each line.						Approximate Interval Between
	thysician/	1	Immediate Cause /Final	dial Infa					Onset and Death Minutes
	Medical Examiner		and the second s	consequence of):					
	Lxammer	-	Sequentially list conditions, b. Hypert	ension					Years
	ed nsit	Examiner	if any, leading to immediate Due to (or as a discusse. Enter Underlying Cause (Disease or injury	consequence or,					
	xecut n and ial-tra		that initiated events C.	consequence of):				-	
Ö	death certificate be executed ne attending physician and ed for use as the burial-transit	Physician/Medical	d					_	
8760	tificat ng ph s as th	Mec	IF FEMALE:						
39 ×	th cer ttendii or use	ian/	23b. Was decedent pregnant 1 2sc. If yes, outcome of	Fetal death 3	Ectopic pregnanc	у		23d. Dat	te of delivery nth Day Year
Box	sician: The law requires that the death certificate certificate has been signed by the attending prector, page 2 should be detached for use as	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unknown	ime of death 5 l	Other (specify)			1410	July 100
P.O.	The law requires that the ate has been signed by the page 2 should be detach	by Ph	Part II. Other significant conditions contributing to death but	not resulting in the	underlying cause giv	en in Part I.	23e. Did tob	acco use contr	ibute to the cause of death?
Š,	uires t n sign uld be	q pe	Hyperlipidemia, Congestive	Heart Fa	ilure		1 □ Ye	s 2 💢 No	3 Probably 4 Unknown
oro	w requ	Completed					24a. Was an		Were autopsy findings available prior to completion of cause of
Şec	The lar	com		-			autopsy perform 1 \sum Yes 2	ned?	death?
<u>rg</u>	sian: T	Be	25. Was case referred to medical examiner?			ace of Death (Check			Assisted
5	Physic this co	은		t 2 ER/Outpatie		4 ☐ Nursing Ho			er (Specify) Living
n oi	ding F h. After funer	Certificate:	1 X Natural 5 ☐ Pending (Month, Day,	Year) 28b. Time of injury	work		28d. Describe hov	w injury occurre	ed
Sio	Attendary deat	rifi		/ - At home, farm, st		163 2 1140	28f. Location (Str	eet and Numbe	er or Rural Route Number,
Division of Vital Records,	al or a after a l Dire		building, etc.	(Specify)		ļ	City or Town,	State)	
_	To the Hospital or Attending Physician: "Thin 24 hours after death as the funeral Director. After this certification completely filled in by the funeral director,	Medical	29a. Certifier 1 Certifying Physician: To the best of m (Check 2 Medical Examiner: On the basis of examiner)						
	the H thin 24 the F mplet	Me	only one) 3 Certifying Nurse Practitioner: To the		e, death occurred at t	ne time, date and pla	ice, and due to the	cause(s) and m	nanner as stated.
	5		29b. Signature and title of certifier	W	29c. License	34590			d (Month, Day, Year) 20, 2012
,	05 gm		30. Name and address of person who completed cause of dea	ath (Item 23a) (Type		J+J J U		TIALUII 2	,
	1			isconsin		211, Beth	nesda, Ma	aryland	20814
	Sta			Signature					
	Registr	ar	HALL OF TALE YOUNG Y	7					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 2 for State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Physician/ Margaret E. Peterson 2012 3:15 P M March Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Montgomery Montgomery Village Montgomery Village Health Care 8. Date of Birth (Month, Day, Year)

Jan. 17, 1920 Birthplace (State or Foreign Country) lf Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** Hours 92 1 □ M 2 🔀 F Director 578-18-3479 Washington, DC Usual Residence of Deceden 10d. Inside City Limits 10c. City, Town or Location 10a. State at the Maryland Director must be notified 1 Yes 2 X No 28a-f Gaithersburg MD Montgomery 10g. Citizen of What Country? 10f. Zip Code or 10e. Street and Number 23a Funeral 20882 USA 21000 Goshen Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) death 14. Race - American Indian 12. Was Decedent Ever in U.S. Examiner Armed Forces?

1 Yes 2 No Black White etc or. 1 Never Married 2 Married Specify White þ Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. If Yes, Give Year or Dates "natural", 3 XWidowed 4 Divorced Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry th and Mental Hygiene.
27 is marked other than traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Be 18. Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First, Middle, Last) ပ Elizabeth Patterson Walton William Linkins 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health at Important: If item 27 is any injury or other trau 21000 Goshen Road Gaithersburg, MD_20882 Edward O. Peterson / son 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Final Journey Crematory 3/22/12 Woodbine, MD 4 ☐ Donation 5 ☐ Other (Specify) Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. CLarksville, MD 21029 21. Signature of Funeral Service I with M01651 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Congestive Heart Failure Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of Hypertension **Examiner** Sequentially list conditions, if any leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): Chronic Obstructive Pulmonary Disease Cause (Disease or injury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-tra Due to (or as a consequence of): physician Pneumonia Physician/Medical Division of Vital Records, P.O. Box 68760 the attending pl for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Year Day Pregnant at time of death Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy performed? 1 🗌 Yes 2 🗌 No 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 X Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No 1 Inpatient 2 ER/Outpatient 3 DOA ျှ 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 27. Manner of Death 1 X Natural injury 5 Pending 1 Yes 2 No Investigation Accident within 24 hours after death

To the Funeral Director: A
completely filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 115 March 20,2012 D41162 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5 V. Ganti 19529 Doctor Drive Germantown,

DHMH 17 Rev 06-2011

State

Registrar

31. Date filed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 2. Date of Death 3. Time of Death . Decedent's Name (First, Middle, Last) Month 19^{ay} 2ď12 Physician/ 6:30 A Elizabeth Mildred Peck Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Harford Bel Air 1941 Cypress Drive If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) **Funeral** Country 97 Director 105-16-6147 1 M 2X F 11/27/1914 Indiana Usual Residence of Deceden or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location 10b. County within 72 hours after death with the Maryland Director Harford Bel Air MD 1 Yes 2 No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral **IISA** 1941 Cypress Drive 21015 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give 14. Race - American Indian, 11 Marital Status Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: White 3 XWidowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) 12 College (1-4 or 5+) Home Design Interior Decorator Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ith and Mental F 27 is marked of traumatic even Elizabeth Firisch John Quinn 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Jodi Wojciechowski 1941 Cypress Drive, Bel Air, MD 21015 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 Burial 2 X Cremation 3 Removal from State 4 Dopation 5 Other (Specify) 03/26/2012 Glen Burnie, MD Atlantic Crematory 22. Name and Address of Facility Schimunek Funeral Home, Signatu of Funeral Service Licenses 610 W. MacPhail Rd., Bel Air, MD 21014 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ Myocardia disease or condition Medical resulting in death) (or as a consequence of) **Examiner** Sequentially list conditions, Examine Due to lor as a consequence of cause. Enter Underlying that the death certificate be executed Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last burialphysician Physician/Medical P.O. Box 68760 as IF FEMALE nse 23c. If yes, outcome of pregnancy 23d. Date of delivery 23h. Was decedent pregnant Live Birth 2 Fetal death 3 Ectopic pregnancy Month in the past 12 months? Day Year for 5 Other (specify) Pregnant at time of death 1 Yes 2 No signed by to 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has be autopsy page 2 death? 1 🗌 Yes 2 🗌 No 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 K Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 IDOA ၉ completely filled in by the funeral 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certificate: **X** Natural 5 Pending Investigation 6 Could not be Accident 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Medical 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29d Date signed (Month. Dav. Year 29b. Signati

- 5 m

State Registrar KARL SPECTOR, md 2014 Tollgate R& Bel Air, md
Date filed (Month, Day, Year)

32 Registrar's Signature

MAR 2 3 2012 Registrar's Signatu

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ March 21°, 201°2° 3:30 Rose M. Palencar Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Carroll Sykesville Oakland Manor Assisted Living Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In yrs. last birthday) **Funeral Director** 205-03-9832 1 M 2 X F 101 Yrs. Nov 2, 1910 Pennsylvania Usual Residence of Decede or 28a-f show 10d. Inside City Limits 10b. County 10c. City, Town or Location with the Maryland Director the Medical Examiner must be notified 1 Yes 2 XNo Owings Mills Maryland Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Numbe Funeral 23a 21117 USA 12 Liberty Ridge Court permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "name" any injury or other transfer. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Armed Forces?
1 ☐ Yes 2 🔀 No If Yes, Give Black, White, etc ð 1 Never Married 2 Married White 1 ☐ Yes 2 X No Specify. 3 XWidowed 4 ☐ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Own Home Homemaker 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ၉ Anna Sorokas Michael Baran 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 12 Liberty Ridge Court Owings Mills, Maryland 21117 Joseph S. Palencar, Jr., Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1X Burial 2 \square Cremation 3 \square Removal from State 4 \square Donation 5 \square Other (Specify) 03/26/12 Dallas, PA Sacred Heart Cemetery Signature of Funeral Service License 7 Thomas Gregor MacNabb Funeral Home, P.A. 301 Frederick Road Catonsville, Maryland 21228 23a. Part 1. Enter the disease, or complications in tracaused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Interval Between Onset and Death Immediate Cause (Final nontra Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and that initiated events Due to (or as a consequence of): resulting in death) Last by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? performed 2 🗆 No Yes 2 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 🗌 Nursing Home 5 🗌 Residence 6 🗹 Other (Specify 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မြ 1 🗌 Yes 2 No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? 1 Natural Accident Suici-5 Pending injury Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated extifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check only one nd title of cert 29b. Signature a

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day,

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30. Name and address of person who completed cause of death (Item 23a) Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Florian Peterson		I- For State	tate of M	aryland		artmer rtificat			nd Me	ental H	ygiene	Reg. No	20		2 0911
Physician Medical Examine	1/	Registrar 1. Decedent's Name (First, Midd Florian Peters									2. Date of D Month March 1	eath			3. Time of Death 0413 hrs
		4a. Facility Name (if not instituti Johns Hopkins Bayvi)			City, Town, Baltimore		on of Death			4c. County of	f Death	
Funeral Director	- 1	5. Social Security Number 220–20–0625	6. Sex		e (In yrs. I	last birthda	-	If Under 1 Y		nder 24Hrs urs Min	_			Foreig	hplace (State or number) Maryland
м апу	-	Usual Residence of Decedent 10a. State 10b. County			10c. City	, Town or	Location				1 - 1 / 1				10d. Inside City Limits 1 XXYes 2 No
the Maryland a or 28a-f sho	rector	Maryland N/			ва	ltimo		Of. Zip Code					itizen of Wha		itry?
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. The Maryland State of the "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.			12. W	as Decedent med Forces' Yes 2	No		If Yes,	Decedent of I specify Cub	Hispanic (an, Mexic	an, Puerto	pecify Yes or Rican, etc.)			Americ etc,	can Indian, Black,
n "natural",	잙	3 Widowed 4 Di 15. Decedent's Education (Spe Elementary/Secondary (0-12)		3:	npleted)	16a. De	cedent's	es 2 X N Usual Occup of working I	oation (Gi	ve kind of v		16b.	Specify: Kind of Bus	Whj	
215-0036 be filed within 7 ntal Hygiene. rked other than ent, the Medic	~	10 17. Father's Name (First, Middle				Fore	eman				(First, Middl	e, Maide WSK i	n Surname)	nufa	acturer
MD 2121 d 2 should be fi th and Mental I n 27 is marked numatic event,	ੂ	Florian Peters 19a. Informant's Name/Relation Raymond Peterso	ship (Type, Pri	·					eet and N	lumber or f	Grabe Rural Route N OWN, M	lumber, (City or Town		
More, Pages I and I healt with I fitem		20a. Method of Disposition 1 X Burial 2 Crematio 4 Donation 5 Other S		oval from St	ate	crematory	or other	n (Name of o place) Ceme			Date 23/201		Location - 0		Fown, State Maryland
6	4	21 Signature of Funeral Service	Licensee	rsv.	<u>v_</u>					r Fun r Str	eral H eet Ba	omes Itim	P.A. ore,	Mary	yland 21231
Physician /Medical Examiner		23a. Part I. Enter the disease, o failure. List only one cause immediate Cause (Final disease or condition resulting in death)	on each line. a. Conge	that caused estive Hea or as a cons	art Failu	re	enter the	mode of dyin	g, such a	s cardiac o	r respiratory	arrest, sh	nock, or hear	t	Approximate Interval Between Onset and Death
i di	llner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	b. Due to (or as a cons		,				<u> </u>					
recuted and transit		(Disease or injury that initiated events resulting in death) Last	d	or as a cons	,										
ox 68760, eath certificate be execut attending physician and for use as the burial - transcription and the control of the cont	D –	UNPENDED IF FEMALE: 3b. Was decedent pregnant in t	230.	DED #18 f yes, outcom	perFH me of preg	G92	_					23	3d. Date of d		
by Box 6876C the death certificate by the attending physiched for use as the b	Iysician	past 12 months? 1 Yes 2 No 9 Un	4	Live birth Pregnant at Unknown	time of de	2 Leath 5	=	death 3 (Specify)	BEcto	pic pregna	ancy		Month	D	ay Year
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Division of Vital Records, P.O. Box 68760, within 4 Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transitical Certification: TO Be Completed by Directorian Madicial Expedited 15.	панс										1 Ye	as an topsy rformed? s 2	pri de		opsy findings available ompletion of cause of
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To the Hos within 24 h To the Fun		one) Medical Exa			-			, in my opinie	on, death	occurred a		ite and pl	lace, and du	e to the	cause(s)
		29b. Signature and title of certifi	all						onse numb	er			Date signed		th, Day,Year)
6811	1	D. Name and address of person Laron Locke MD.	who co mplete Assistant Me		•	,	/. Baltii	more Stre	et, Balt	timore, M	MD 21223				
Stat Registra		31. Date filed (Month, Day, Year)	0.2012	32. Rejistra	≮s Signatu	re	Lau	11							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State	e of Ma	aryland			nt of H te of L			ental Hy	67		
			Registrar 1. Decedent's Name (First, Mi	ddle Last)			007	imoai	10 01 2	- Can	,	2. Date of De	Reg. No.	2017	- 3. Time of Death
	Physici	an	HAD BELL	TO								03	Day i G	- 1	1 1 Ca . 1 12 6 M
	/Medic		11 ATICKY	100	SE			4h City	, Town, or	Location	of Death	V 3		County of De	
	Examin	er	4a. Facility Name (If not institu										10.		uii i
			LEVINDALE H 5. Social Security Number	EBREW HON		io (In vre li	ast birthday)		BALT :			8 Date of Bir	th	N/A	irthplace (State or Foreign
	Funeral		219-12-8229	1. M 2□		87	Yrs.	Months		Hours	Min.	8. Date of Bir (Month, Da 06 / 18	y, Year)		Country) MD
	Director		Usual Residence of Decedent			07						00/10	77 172	. 7	110
	land ow		10a. State 10b. Cou			10c. City	, Town or Lo	cation							10d. Inside City Limits
	Mary -f sh ijed a	ţō	MD	N/A			BALT	IMOR	E						1. Yes 2 No
	the 728a	Director	10e. Street and Number					10f. Zi	p Code				10g. Citi	zen of What 0	Country?
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ر د م	after or Ite nine		1 Never Married 2 N	farried 1.	Yes 2□	No		irres, spe 1 ⊟ Yes		Specifi		nican, etc./		Black, Wh	inte, etc.
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Baltimore.	permit. Pag Department Important: I any Injury o		4 □ Donation 5 □ Othe	1		OHE	B SHAL			-		1/2012			TOWN, MD
39	permit. Departn Importa any Inju		21. Signature of Funeral Ser	ce licensee					and Addre		. 50				S., INC.
	~ C □ = @ O		Muchon	Bug	7									SVILLE,	MD 21208
100			23a. Part1. Enter the disease shock, or heart failure.	e, or complica v ons List only one cause	tnat cause e on each li	d the deatr ine.	i. Do not ent	er the mo	ae oi ayir	ig, such a	as cardiac o	r respiratory a	arrest,		Approximate Interval Between Onset and Death
6	Physician		Immediate Cause (Final disease or condition resulting in death)	a	Den	nent	TA								
	/Medical Examiner		resulting in death)	Di O	ue to (or as										
	Examine	_	Sequentially list conditions,	b. 1/	ue to for as	N20N		ISER	tse						
	ed sit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	~	de to tor as	a consequ	derice on								
_	icate be executed physician and the burial-transit	хап	that initiated events resulting in death) Last	c	ue to (or as	a consequ	uence of):								
8760.	be exician ician buria	ᄪ			,		,								
387	phys the	dical		d											
9 ×	leath certific attending p	Physician/Me	IF FEMALE:	23c. If ye	es, outcome	e pf pregna	incy							23d. Date of	delivery
Box	eath atten for u	Sian	23b. Was decedent pregnant in the past 12 months?	1 🗆	Live birth Pregnant a	2 Feta	Ideath 3	□Ectopic □ Other (s	pregnancy	у				Month	Day Year
Ö	the d	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown		Unknown		ou o E	J 011101 (c							
۵.	that t ed by detar	유	Part II. Other significant con	ditions contributing	g to death b	out not resu	ulting in the u	nderlying	cause giv	en in Par	t I.	23e. Did	tobacco	use contribute	to the cause of death?
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Ö	w requires that the de been signed by the should be detached	Completed										24a. Was	s an	24h Were	autopsy findings available
Ä	has ge 2	П										auto	opsy formed?	prior death	to completion of cause of ?
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ō	ling Phys I. After this funeral di	٠. ت	27. Manner of Death	28a.	1 ☐ Inpati Date of Inju (Month, Da		ER/Outpatier 28b. Time o		28c. Injui Wor	4		me 5 ☐ Res 28d. Describe			ресіту)
L C	ding h. Afte fune	Certification:	1-Natural 5 □ Pe	nding estigation	(Month, Da	ay Year)	Injury	М		rƙ? Yes 2	⊒No				
· ·	or Attencatter death Director: in by the	lica	3 ☐ Suicide 6 ☐ Co	uld and he	Place of in	jury - At ho	ome, farm, str	reet, facto	ory, office			28f. Location	(Street a	nd Number or	Rural Route Number,
Si	lor A after Dire	ertil	4 ☐ Homicide de	termined	building, e	etc. (Specif	y)					City or To	own, State	e)	
	spita ours neral			ifying Physician:											
	To the Hospital or Attending Physician: The law requires that the death certification 24 hours afterdeath. To the Funeral Director: After this certificate has been signed by the attending prompletely filled in by the funeral director, page 2 should be detached for use as	Medical			the basis of manner s		tion and/or ir	nvestigatio	on, in my	op i nion, c	leath occur	red at the time	e, date an	d place, and	due to the cause(s)
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	- > - 0		1 Slaw	PHY	15101	An			Dog	064	533		0	3-20	-2012
	10 m		30. Name and address of per	son who complete	d cause of	death (Iten	n 23a) (Type,	Print) L	EVIN	DAL	E CIE	RIATR	1C (CTR	
	1 0		30. Name and address of per	MACA	mD	24	34 W	-BEL	VEDO	ERE	AVEN	WE BA	IM	ORE M	D 21215
	Sta	ate	31. Date filed (Month, Day, Y	ear)	32. Regist	rar's Signa	ature								
	Regist	rar	MAR 2 3 2012	Busers	J 18	. 40	wes								

DHMH 17 Rev 1/2001

REICHENBELG, CHARLES Division of Vital Records, P.O. Box 68760

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	Physicia Medic		1. Decedent's Name Charles		chenberg	Jr.						2. Date of De Month	Day	300	Year	3. Time of Death A	
	Examin	er	4a. Facility Name (if Sam)	AGNES	HOSP			3	AC	hn (ne			County o	f Death		
	Funeral Director		5. Social Security Nu 216-32-4 Usual Residence o	536	Sex 7 ▼ M 2 □ F	Age (In yrs. Ia 75	ast birthday) Yrs.	If Under Months	1 Year Days	If Under Hours		8. Date of Bir (Month, Da Jan • 8,		66	Count	lace (State or Foreign ry) yland	
	faryland Ba-f show ufied at	Director	10a. State	10b. County Baltimor	·e	1 '	, Town or Lo							<u> </u>	10	0d. Inside City Limits 1 ☐ Yes 2 🖾 No	
	with the N 23a or 2 ust be no	Funeral Di	10e. Street and Num 2009 C11	hber Lf de n Roa	d		-	10f. Zip		21228			10g. Cit	izen of Wi	nat Coun	try?	
920	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If time Z7 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	11. Marital Status 1 Never Marri 3 Widowed 4		12. Was Deceder Armed Forces 1 2 Yes 2 If Yes, Give Year or Dates	s? □ No	'	Was Decede f Yes, speci	fy Cubar	n, Mexican	gin? (Spe ı, Puerto I	cify Yes or No- Rican, etc.)		14. Race Black Specify:	White, e		
21215-0036	iin 72 hou ie. han "natu e Medica	Completed	(Spec	15. Decedent's E cify only highest gra ndary (0-12)		or 5+)	(Give i	dent's Usual kind of work O NOT use	done d		t of workii	ng	16b. Ki	ind of Bus	iness/Inc	lustry	
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Balt	permit. Depart Import any inj		21. Signature of Fun	eral Service Licens	See 1017 2 ¥		22 F	Name and	Addres	s of Facility	Ste f Ca	rling A tonsvil	ishto lle,	n Sc Inc.	hwab o M	Witzke D 21228	
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Box 68760	the attending physician hed for use as the burian	Physician/Medica	IF FEMALE: 23b. Was decedent p in the past 12 m 1 ☐ Yes 2 ☐ 9 ☐ Unknown	nonths?	23c. If yes, outcom 1 Live Birtl 4 Pregnan 9 Unknow	n 2 🗀 Fetal t at time of de	Ideath 3 🗌	Ectopic pr Other (spe		/				23d. Date Mont		ry Day Year	
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Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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permit. P Departm Importal any injur			neral Service License			1651	22. Name Going	and Address	s of Facilit	atio	n Serv	ice	P.O.	Box		20
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To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	Medical	(Check 2	Certifying Physic Medical Examin	er: On the basis of	examination	n and/or inv	vestigation, i	n my opinio	n, death oc	curred at	the time, date	and place	e, and due	to the cau	ise(s) and manner	stated
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3			ess of person who co			, , , , ,	-	1105-	_	, -						
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DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) Physician/ Alyce Dyson Schmidt Medical 4a. Facility Name (if not institution, give street and number) **Examiner** Shady Grove Adventist Hospital **Funeral** cial Security Number 6 Sex 7. Age (In vrs. last birthday) 1 □ M 2 🙀 F **Director** Yrs 183-14-2395 88 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location Examiner must be notified at Director MD Rockville Montgomery 10e. Street and Number 23a 1235 Potomac Valley Road 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "natural" Completed 3 ₩ Widowed 4 □ Divorced Year or Dates the Medical 15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) Edgar Dyson 19a. Informant's Name/Relationship (Type, Print) .0 David W. Craig/son 20a, Method of Disposition permit. Page 1 a Department of H Important: If ite any injury or ot 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee MO1651 Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Advanced Dementia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): the burial-transit that the death certificate be executed Failure to Thrive that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Box 68760 as nse 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 🔀 No Pregnant at time of death 1 Yes 2 9 Unknown P.O. þ Records, Completed certificate or Attending Physician: 25. Was case referred to medical of Vital Be 1 Yes 2 No 1 🔀 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA ပ this funeral 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of Natural 5 Pending Division s after death. 2 Accident 3 Suicide 4 Homicide Investigation 6 Could not be determined To the Hospital within 24 hours a To the Funeral D Medical 29a. Certifier completed (Check 29b. Signature and title of certifier

Reg. No. 2. Date of Death 3. Time of Death Day 2012 Month 14 1:00 P^{M} March 4b. City, Town, or Location of Death 4c. County of Death Montgomery Rockville If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Days April 3, 1923 Pennsylvania 10d. Inside City Limits 1 X Yes 2 No 10f. Zip Code 10g. Citizen of What Country? 20850 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Specify: White 1 Yes 2X No Specify. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Business/Office Equipment Business Owner 18. Mother's Name (First, Middle, Maiden Sumame) Alice Bastow 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Glenhurst Court N. Potomac, MD 20878 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Final Journey Crematory 3/19/12 Woodbine, MD Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, M MD 21029 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Cardiopulmonary Arrest 23d. Date of delivery Ectopic pregnancy Month Day Vear 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4X Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? death? 2 No Yes 2 No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at 28d. Describe how injury occurred work? 1 Tyes 2 No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 😾 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 🛄 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) penjalle March 16, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Usha Yenigalla 9901 Medical Center Drive Rockville, MD 20850 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

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		Registrar	i unca	e or Death		Reg	g. No.	3. Time of Death
Physicia ledical Exami	ner	Decedent's Name (First, Middle, Last) Marsha Ann Shinkman				Month March 19, 2	Day Year 2012	0850 hrs
		4a. Facility Name (if not institution, give street and number) Suburban Hospital		4b. City, Town, o	r Location of Dea	th	4c. County of De Montgomery	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs	. last birth	day) If Under 1 Ye	ar If Under 24H	rs. 8. Date of Birth	(MM/DD/YYYY) 9. I	
Director		114-34-1188 1_M 2XF 69		Yrs. Months Da	ys Hours M	02-13-1	.943	eign CountryNew York
P	-	Usuel Residence of Decedent 10a, State 10b, County 10c, Cit	v Town o	r Location	 			10d. Inside City Limits
w any		100,000	•					1 X Yes 2 No
land f show	5	nary tana membersey	thesd			1.0	0111	
Mary 28a-	Director	10e. Street and Number		10f. Zip Code		10	g. Citizen of What Co	ouritry ?
3 or		5607 Wood Way		20816			U.S.A.	
with pen	E	11. Marital Status 12. Was Decedent Ever in Armed Forces?	U.S.	 Was Decedent of H If Yes, specify Cuba 	ispanic Origin? (an. Mexican. Puer	Specify Yes or No- to Rican, etc.)	14. Race - Am White, etc	erican Indian, Black,
deatl	Fune	1 Yes 2 X No		955			7.71	-d+-
after iner	ò	3 Widowed 4 Divorced If Yes, Give Year or Dates:		1 Yes 2 X N			Specify: Wh	
hours		15. Decedent's Education (Specify only highest grade completed)		ecedent's Usual Occup uring most of working lit			16b. Kind of Busines	ss/muusiry
36 n 72 ical]	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	٨	lministrato	r		Universit	v
Withi Wed the	통	17. Father's Name (First, Middle, Last)	AC	IIIIIIISCIACO		ne (First, Middle, M		
21215-0036 Mental Hygiene. marked other than "natural", or items 23a or 28a-f she cevent, the Medical Examiner must be notified at once.		1	ara		Ebba	no (r not, middle, m	Rudwa11	L
12.	o Be	Marshall Frib 19a. Informant's Name/Relationship (Type, Print)		Mailing Address (Stre	22	r Rural Route Numi	per. City or Town, St	ate, Zip Code)
MD 2 d 2 shou lith and M n 27 is n	٩	Christopher J.Shinkman/husband	9.7	07 Wood Wa				
and 2 and 2 tealth tem 2			. Place of	Disposition (Name of c		Date	20c. Location - City	
Ore ges 1 rof H		1 Burial 2 X Cremation 3 Removal from State		ry or other place) Lal Cremato	ru 3/	22/2012	Falls Chu	rch. VA.
timen trant		4 Donation 5 Other Specify: N: 21. Signature of Funezal Septice Licensee	ation		<u> </u>			
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once	Į	21. Signature of uneral service Licensee		22. Name and Addre	uneral H	omes, Inc	nbia, MD.	21045
Physician	=	23a-Part I. Enter the disease, or complications that caused the dea		enter the mode of dying	g, such as cardiac	or respiratory arre	st, shock, or heart	Approximate Interval
/Medical		failure. List only one cause on each line.						Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence		image				+
		h	,-					
	اق	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence	of):					
	횰	Course Enter Underlying Cause (Disease or injury that initiated counts resulting in death). Last Due to (or as a consequence	of):					- 24
executed an and al - transit	cal Examiner	d.	·					
		UNPENDED X AMENDED 23a pe		g926 4-9-1	2 vt 		Lood Data and dis	
Box 68760, e death certificate be the attending physic ed for use as the bur	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of prediction of predictions are supported by the second of th	egnancy 2	Fetal death 3	Ectopic preg	nancy	23d. Date of delive	Day Year
OX 68 leath certi e attendin for use a	cia	past 12 months? 4 Pregnant at time of						
BO) le deatl the att	ysi	1 Yes 2 No 9 Unknown 9 Unknown						
that the detach		Part II. Other significant conditions contributing to death but no Diabetes Mellitus; Renal Failure	t resulting	in the underlying cause	given in Part I.			to the cause of death? robably 4 Unknown
S, F quires en sign ald be	Completed by	Diabetes Wellitus, Ivental Fallure				24a. Was a	in 24b. Were	autopsy findings available
Division of Vital Records, ral or Attending Physician: The law requir rs after death. **I Director: After this certificate has been s led in by the funeral director, page 2 should t	ple					autops perform		to completion of cause of
Rec The l cate l page	Ç.					1 ✓ Yes 2	2 No 1 🗸	Yes 2 No
Vital Rec ysician: The his certificate	Be (25. Was case referred to medical examiner? Hospital: 1 Inpatient 2			Other Nur			
Pysic Aldir	2	1 ✓ Yes 2 No Inpatient 2		tpatient 3 DOA	jury at Work?		Residence 6 Ot	ner:
Ing P	ino	27. Manner of Death 1 ✓ Natural Pending 28a. Date of Injury (Month, Day, Year)	200. 1	ime of Injury 28c. In	Yes 2 No	200. Describe n	ow injury boodined	
SiOn trendeath death ctor:	ati	2 Accident Investigation		'_		29f Location (C	tract and Number or	Rural Route Number, City
Divis ospital or A hours after meral Dire	Certification:	3 Suicide 6 Could not be determined (Specify)	nome, rar	m, street, factory, office	pullarig, etc.	or Town, St		Adia Node Namber, Ony
spits hours neral	S	4 Homicide						
第 2 国 5	cal	29a. Certifier (Check only 1 Certifying Physician: To the best of my knowl one) Wedical Examiner: On the basis of examination						
To the within To the comple	Medical	and manner stated. 29b. Signature and title of certifier			nse number		29d. Date signed (
	~				C.M.E.		March 20, 201	
~		MM V		1/4/1				
		30. Name and address of person who completed cause of death (It Russell Alexander MD. Assistant Medical Exa		900 W. Baltimor	e Street Ball	imore. MD 212	223	
	l a l	Loo De Sanda Cian						
S Regis	tate trar	WAT O A 2010 6	A.	parle			YCAIF	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death OCH KAVEN COMMUNI) N/A Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🗷 F Min. Hours April 1th, 28, 1932 79 219-28-6010 Yrs. Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits N/A Baltimore 12 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21213 3405 Elmora Avenue USA 11. Marital Status 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 1 Never Married 2 Married 1 X Yes 2 ☐ No If Yes, Give Black, White, etc. 1 Yes 2 No Specify: 3 Divorced 4 Divorced Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Furniture Mover Davidson Trailer 17. Father's Name (First, Middle, Last) Mother's Name (First, Middle, Maiden Surname) Josephine Svekla Emil Schott 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3405 Elmora Avenue-Baltimore, Maryland 21213 Dolores Schott-spouse 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 为☐ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) Garrison Forest VA Mar.28,2012 Owings Mills, Maryland 4 Donation 5 Other (Specify) . Signature of Funeral Service Licensee 22. Name and Address of Facility 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) yes, outcome of pregnancy Live Birth 2 Fetal death 3 Ectopic pregnancy Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year ☐ Unknown 2

Physician/ Medical Examiner

signed by the attending physician and d be detached for use as the burial-tran

this certificate has

eral Director: After th filled in by the funeral

death.

within 24 hours a To the Funeral D the Hospital

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or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760

Examine

Physician/Medical

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Certificate:

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29a. Certifier

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permit. Page 1 and 2 should be filk Department of Health and Mental I Important: If item 27 is marked of any injury or other traumatic eve

Medical Examiner must be notified at

with the Maryland

death v

within 72 hours after 21215-0036

filed

Maryland

Baltimore,

Sequentially list conditions, if any, loading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?											
1 🗆 Yes 2 🗔	No 3 ☐ Probably 4 X Unknown										
24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No										

25. Was case referred to medical examiner? Hospital 1 🗌 Yes 2 🔀 No 1 🔲 In 27. Manner of Death 28a. Date o

			20. I lace 0	Death (Chet	K Ulliy	one)	
patient 2 🗆	ER/Outpatient	3 🗆 D4	OA Other:	Nursing H	ome 5	5 Residence	6 ☐ Other (Specify)
finjury , <i>Day</i> , Year)	28b. Time of injury	м 2	28c. Injury at work? 1 ☐ Yes			Describe how inju	

26 Bloop of Dooth (Chaole

Natural 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined

2 🗌 No	
	28f. Location (Street and Number or Rural Route Number, City or Town, State)

	only one)					st of my know
29b.	Signature	and title	of certifier	sh	· ~ ·	MM

or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated dedge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year) MAR 2

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ John Edgar Sandrock 21,2012 March 6:30 A. M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore County 18201 Bunker Hill Road Parkton Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours 215-22-2238 85 1 **X**M 2 □ F **Director** Dec.30,1926 Baltimore, MD. Usual Residence of Decedent or 28a-f shov notified at show 10a. State 10c. City, Town or Location Director 10d. Inside City Limits Maryland Baltimore County Parkton 1 Yes 2 XNo 10e. Street and Numbe 9 ems 23a or must be r 10f. Zip Code 10g. Citizen of What Country Funeral 18201 Bunker Hill Road 21120 United States items death death 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black, White, etc. ò þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify. White "natural" Completed 3 Widowed 4 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. I other than " Elementary/Secondary (0-12) College (1-4 or 5+) **06** Captain United States Navy Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) and Mental I 2 Department of Health and Ment. Important: If item 27 is marked any injury or cat. Edgar Poe Sandrock Dorothea Peters 19a. Informant's Name/Relationship (Type, Print) (Wife) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Katherine (nee Morris) Sandrock 18201 Bunker Hill Road Parkton, MD. 21120 altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Lown State
(Hariord County) 1 Burial 2 Cremation 3 Removal from State Evans Fureral Charel and Cremetion Services, Inc. Thursday 4 Donation 5 Other (Specify) March 22,2012 Forest Hill, Maryland Jeffrey L. Gair, Sr. O. S.P. Plane and Address of Facility ives Funeral and Cremation Center, P.A.

A. A. Lic. #M00677 2325 York Road Timonium, Maryland 21093-2215 It is the the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph_sician/ Fibrillation disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner abetes Sequentially list conditions if any, leading to immedicause. Enter Underlying Cause (Disease or injury that initiated events Examin Hospital or Attending Physician: The law requires that the death certificate be executed perl resulting in death) Last burialphysician s the buria Physician/Medical Division of Vital Records, P.O. Box 68760 d 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: use 23b. Was decedent pregnant 23d. Date of delivery for in the past 12 months?
1 ☐ Yes 2 ☐ No Month 9 Unknown Unknown signed by 1 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by tate has been signated bage 2 should be 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed certificate 1 Yes 2 L after death.

Director: After this certific d in by the funeral director, Be 25. Was case referred to nedical 26. Place of Death (Check only one) examiner? Hospital 1 Yes 2 No Other: 은 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, 27. Mann of Death 28a. Date of injury (Month, Day, Year) Certificate: 28c. Injury at 28b. Time of 28d. Describe how injury occurred Natural 5 Pending Investigation
6 Could not be 1 Yes 2 No 2 Accident 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) within 24 hours To the Funeral Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d, Date signed (Month, Day, Year, D0057690 Wednesday, March 21, 2012 30. Name and address of person who completed cause of de eath (Item 23a) (Type, Print) Joseph Pallan,M.D. 1205 York Road Suite 30 Lutherville, Maryland 21093

DHMH 17 Rev 06-2011

Registrar

31. Date filed (Month, Day, Year)

32. Registra

			Please	Type or Pri					_		_	
		-	For State	State of Ma	aryland /	Department Certificate				giene Reg. No	71117	09121
			Registrar 1. Decedent's Name (First, Middle, Las	t)	0	, ,	0, 00		2. Date of Dea	ath		3. Time of Death
	Physicia Medic	al	4a. Facility Name (if not institution, give	street and number)	Senl		Town or lo	cation of Death	OB -	i 8	- 2012 County of Deat	9:32 A M
	Examin	er	Coastal Hospice	at the	Lake	9	Salis	bury			Wicon	nico
	Funeral Director		5. Social Security Number 6. S	7. Age	e (In yrs. last bi	Yrs. If Under Months		Under 24 Hrs. lours Min.	8. Date of Birt (Month, Da	1.7		thplace (State or Foreign untry)
	3	١	Usual Residence of Decedent 10a. State 10b. County		10c. City, To	wn or Location				,		10d. Inside City Limits
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	be filed within 72 hours after death with the Maryland ental Hygiene. ked other than "natural", or items 23a or 28a-f sho ic event, the Medical Examiner must be notified at	ral Di	10e. Street and Number) 1	101	10f. Zip		020		10g. Ci	tizen of What Co	ountry?
	eath wi	Funeral	8563 ()\d\	12. Was Decedent E Armed Forces?	ever in U.S.	13. Was Deced		930 nic Origin? (Spe Mexican, Puerto	cify Yes or No-		14. Race - Ame Black, Whit	
36	2 hours after death v "natural", or items clical Examiner mu	ρ	1 ☐ Never Married 2 Married 3 ☐ Widowed 4 ☐ Divorced	1 Yes 2 If Yes, Give Year or Dates.	No	1 Yes			, troati, otal,		Specify:	1/2/tp
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	ifiled w tal Hyg id othe event,	To Be	17. Father's Name (First, Middle, Last)	\	C 1			. Mother's Nam		Maiden	Surname)	
Senkb Maryland	should be file and Mental is marked of raumatic eve	-	19a Informant's Name/Relationship (7	ype, Print)	Sent		(Street and		al Route Numbe	r, City o	, Mabe r Town, State, Zi	Code) 21830
-	and 2 sh Health ar tem 27 is		Gloria Sen	-\ \ \ /	wire 9	8562 (519	Baile	ad Bo	1 1	ebror	MD
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M,\\∖kam Baltimore	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Licen		<u> </u>	22. Name an	d Address o	f Facility	1. 1	.,	0	18434
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73	Physician/		sh , or heart failure. List only of lmm late Cause (Final disc se or condition	ne cause on each line	160	dosis						Interval Between Onset and Death
	Medical Examiner		resulting in death)	a. Due to (or as	onsequenc	e of):						
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0	be exe sician burial	I — I	resulting in deathy East	d	·							
3876	irtificate ling phy e as th	/Med	IF FEMALE:	23c, If yes, outcome	of pregnancy						23d. Date of de	Nivers
Box 68760	leath ce s attend d for us	ician	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	1 Live Birth 4 Pregnant a	2 Fetal de						Month	Day Year
P.O. E	at the d d by the etacher	Phys	g Unknown Part II. Other significant conditions of		out not resultin	ng in the underlying	cause given	in Part I.	23e. Did 1	obacco	use contribute t	o the cause of death?
	law requires that the death certificate be nas been signed by the attending physici s 2 should be detached for use as the bu	Completed by Physician/Medica				-			1 🗆	Yes 2	2 □ No 3 □ I	Probably 4 Unknown
cord	aw requas beer	nplet							24a. Was		24b. Were a prior to death?	utopsy findings available completion of cause of
l Re	n: The l ficate h or, page	e Con	25. Was case referred to medical				26. Place	e of Death (Chec	1 Tes			
Division of Vital Records,	hysicia nis certi I directe	To Be	examiner?			Outpatient 3 D	OA Other:	4 Nursing H	ome 5 Res			city) Hospoce
n of	ding Pl th. After the	cate:	27. Manner of Death Natural 5 Pending 2 Accident Investigation	28a. Date of inju (Month, Da		b. Time of injury	28c. Injury a work? 1 🗌 Ye	s 2 \square No	28d. Describe	how inju	iry occurred	in one our
visio	ir Atten ter dea irector: n by the	Certificate:	3 Sulcide 6 Could not 4 Homicide determined	pe 28e. Place of Inj	ury - At home, c. (Specify)	, farm, street, factor	y, office		28f. Location (City or To			ural Route Number,
٥	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has be completed filled in by the funeral director, page 2 s		29a. Certifier Certifying Ph	sician: To the best of	f my knowledg	e, death occured at	t the time, d	ate and place, a	nd due to the c	ause(s) a	and manner as s	tated.
(3)	the Ho hin 24 h the Fur	Medical	only one) 3 Certifying Nu	rse Practioner: To the	best of my kn	owledge, death occu	irred at the ti	me, date and pla	ce, and due to t	he cause	e(s) and manner a	th Day Voorl
	Sor Witt		29b. Signature and title of certifier			590	c.License n	99		3/	ate signed (Mon	iri, Day, Tear)
	6		30. Name and address of person who	completed cause of	death (Item 23:	a) (Type, Print)	IORE	NR.	CALISE	UR	1, MD 2	18.4
	Sta	te	31. Date filed (Month, Day, Year)	32. Registr	ar Signatu e	2. 1/2		0. 1.			/	
	Regist		31. Date filed (Month, Day, Year) MAR 2 3 2012	Charles 1	B. 194	-						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Dona 19 12:30 PM 03 Medical 2012 4a. Facility Name (if not institution, give street and number Examiner Town, or Location of Death 4c. County of Death Univ. of MD Med. Center Baltimore 5. Social Security Number 6. Sex Age (In yrs. last birthday) If Under 24 Hrs Funeral 8. Date of Birth 9. Birthplace (State or Foreign Months Hours (Month, Day, Year) Director 217-24-4193 1 ₹ M 2 □ F June 27, 1929 82 Yrs. Maryland show 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location Examiner must be notified at Director 10d. Inside City Limits 28a-f 1 Tes 2 X No Maryland Baltimore Nottingham Ь 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 4017 Pinedale Dr. 21236 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces ō Black, White, etc. Completed by 1 Never Married 2X Married Baltimore, Maryland 21215-0036 Yes 2 🗓 No "natural", If Yes, Give 1 ☐ Yes 2 X No Specify: 3 🗌 Widowed 4 🗌 Divorced Specify: White Year or Dates. other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Metalurgist Martin Marietta Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Mental Important; If Item 27 is marked o any injury or other traumatic eve once. William . Stoffel Henry Lola Brackett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Priscilla Stoffel/Wife 4017 Pinedale Dr., Baltimore MD20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☐ Burial 2 【 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Atlantic Crematory 03/18/ 2012 Glen. Burnie 22. Name and Address of Facility
Schimunek Funeral Home, Inc
9705 Belair Road Baltimore Signature of Funeral Service Licenses Inc. 21236 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. Immediate Cause (Final or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Physician/ Intracranial hemowhag disease or condition resulting in death) Medical Examiner (TISSUE PLASMINDGEN ACTIVATOR Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Attending Physician; The law requires that the death certificate be executed CEREBRAL VASCULAR ACCIDEN the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) physician Physician/Medical P.O. Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Pregnant at time of death Month Year 4 ☐ Pregnant 9 ☐ Unknown 2 No ate has been signed by the a page 2 should be detached 1 ☐ Yes 2 ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of 24a. Was an certificate has autopsy performed? Yes 2 2 N death? 1 ☐ Yes 2 No filled in by the funeral director, 25. Was case referred to medical examiner?
1 ☐ Yes 2 ▼ No Be 26. Place of Death (Check only one) Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending o the Hospital or Attendii ithin 24 hours after death. o the Funeral Director: A Accident Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 **Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) To the within To the

State Registrar

Mena Wang 1. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

22 S. Greene St. 32. Registrar's Signature

Baltimore MD

29d. Date signed (Month, Day, Year)

12-02018 Leslie Sadler

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2012 09123 1- For State Certificate of Death Reg. No Registrar 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle,Last) Physician/ 1050 hrs March 10, 2012 **Medical Examiner** LESLIE RAYMOND SADLER 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death Johns Hopkins Bayview Medical Center **Baltimore** If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Foreian Months Days Hours AUGUST 29,1958 MARYLANI Country) Director 53 215-76-4786 1 XM 2 F Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 Yes 2 X No BALTO. ROSEDALE MD. 28a-f shov permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygione.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatte event, the Medical Examiner must be notified at once. Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21237 8545 PULASKI HIGHWAY 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Funeral 11. Marital Status 12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces' 1 Never Married 2 Married 2 X No Yes f Yes, Give Yeer or Dates: WHITE 1 Yes 2 No specify: Specify: 3 Widowed 4 Divorced 2 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 APARTMENT COMPANY MAINTENANCE TECH. **6TH** 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) NORMA K. YATES Be MICHAUX J. SADLER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 8545 PULASKI HIGHWAY ROSEDALE, MD. 21237 SPOUSE INEZ SADLER 20a. Method of Disposition

1 Burial 2 X Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State crematory or other place) MARCH 23,2012 GLEN BURNIE, MD. ATLANTIC CREMATORY Donation 5 Other Specify. 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 9705 BELAIR ROAD NOTTINGHAM, MD. 21236 Approximate Interval Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Between Onset and failure. List only one cause on each line. /Medical Death a Contact gunshot wound of head Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause Examiner (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and Physician/Medical AMENDED 23a, 27, 28a-f, per me, g926 4-19-12 sm X UNPENDED attending physician for use as the burial Box 68760, 23d. Date of deliver IF FEMALE 23c. If yes, outcome of pregnancy 3b. Was decedent pregnant in the 2 Fetal death Day Year 3 Ectopic pregnancy Month Live birth past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. 1 Yes 2 V No 3 Probably 4 Unknown Ś ficate has been si , page 2 should b 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy this certificate has performed? death? 1 🗸 Yes Yes 2 No 26.Place of Death (Check only one) 25 Was case referred to medical Be examiner? Hospital: 1 ☐ Inpatient 2 ✔ ER/Outpatient 3 ☐ DOA Other Nursing Home 5 Residence 6 Other: 2 No 1 🗸 Yes ဥ 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day,Year) 28b. Time of Injury After 27. Manner of Death subject shot self ___ Natural 1 Yes 2 X No 5 Pending fd 9:50 am the fd 3-10-12 2 ___ Accident Investigation Location (Street and Number or Rural Route Number, Ci or Town, State) 88545 Pulaski Hgwy. filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 X Suicide Could not be determined (Specify) Baltimore, MD Residence 4 ___ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely Sa 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number March 11, 2012 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) Deputy Chief Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 Jack Titus MD. 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 22^{Day} Physician/ 2012 August Schmidt, Jr. 12:50 A M Louis March Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Montgomery Bethesda Suburban Hospital 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 212-38-3229 Months **Director** 1 XM 2 - F December 28, 1939 Washington, D.C. 72 Yrs Usual Residence of Decedent 28a-f show 10a. State within 72 hours after death with the Maryland notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland Montgomery Potomac r items 23a or ner must be n ò 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20854 11101 Potomac Crest Drive United States 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Armed Forces'
1 N Yes 2 If Yes, Give 1957-Black, White, etc. ō ò 1 Never Married 2 X Married 2 🗆 No Baltimore, Maryland 21215-0036 1963 1 Yes 2 X No Specify. "natural" Specify: White Completed 3 Widowed 4 Divorced Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) the Federal Government Field Operations Manager Be traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) on and Mental h မ Louis A. Schmidt Lillian Anita Melvin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) I and 2 s F Health a tem 27 i Suzanne L. Wilson / Wife 11101 Potomac Crest Drive, Potomac, Maryland 20854 t of Healt : If item ' / or othe 20a. Method of Disposition
1 ⚠ Buriat 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State March 27, Friendship United the place)
Methodist Church Cemetery permit. Page Department of Important: If any injury or once, Friendship, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2012 Signature of Funeral Service Licensee Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 M01305 23a. Part Venter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shook, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Cardiorespiratory Arrest disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Intracerebral Hemorrhage (Non Traumatic) Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) and that initiated events resulting in death) Last Due to (or as a consequence of) this certificate has been signed by the attending physician Be Completed by Physician/Medical as IF FEMALE: Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month 5 Other (specify) Dav Year Pregnant at time of death page 2 should be detached 9 Unknown g Unknown Hospital or Attending Physician: The law requires that the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No 2 No 1 Yes completely filled in by the funeral director 25. Was case referred to medical of Vital 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ဂ္ဂ 1 🏋 Yes 2 🗆 No 1 🕅 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA 27. Manner of Death 1 X Natural 28a. Date of injury 28c. Injury at work?
1 Yes Medical Certificate: 28b. Time of (Month, Day, Year) 5 Pendina Division 2 No Accident Investigation within 24 hours are deat To the Funeral Director: Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined building, etc. (Specify) A Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, geath occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 2 29b. Signature ar 29c. License number 29d. Date signed (Month, Day, Year) D70241 March 22, 2012

State Registrar

oosoam

2012

SCHW

Shanti Nadar, MD 8600 Old Georgetown Road, Bethesda, Maryland 20814

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar Signa

12-02	234
Harry	Singer

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

arry Singer	_	1- For State Certificate of Death Reg. No.											
Physiciai Medical Examin	1/	I. Decedent's Name (First, Middle,Last) Harry Sin	ger			2. Date of Death Month D March 18, 2	ay Year 012	3. Time of Death 1215 hrs					
		ta. Facility Name (if not institution, give street and r		4b. City, Town, Kensingto	or Location of Death		4c. County of Death Montgomery	-					
Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last	birthday) If Under 1 Y	ear If Under 24Hrs.	8. Date of Birth(MM/DD/YYYY) 9. Birth	1					
Director		093-16-1685 1XM 2 F	91	Yrs. Months Da	ays Hours Min.	Aug. 9,		ntry) Poland					
d any	- 1-	Usual Residence of Decedent 10a. State 10b. County	10c. City, To	wn or Location	at or			10d. Inside City Limits 1 Yes 2 No					
Maryland 28a-f show d at once.	ġ -	MD Montgomery 10e. Street and Number		Kensir		10g	Citizen of What Coun						
with the Maryland ns 23a or 28a-f sho be notified at once.	Director	10706 Brunswick Ave.			0895	- No. West Mark	United St						
r death	Funeral	1 Never Married 2 Married 1 Yes	2 No	13. Was Decedent of I If Yes, specify Cub	an, Mexican, Puerto I	ecity res or No- Rican, etc.)	White, etc.	ite					
ours afte atural",	<u>a</u>	15. Decedent's Education (Specify only highest gr	ade completed) 16	6a. Decedent's Usual Occup during most of working I	pation (Give kind of w		6b. Kind of Business/Ir	ndustry					
27	Completed	Elementary/Secondary (0-12) College 5+	(1-4 or 5+)	Sociologist			Healthc	are					
21215-0036 Montal Hygiene. marked other than "		17. Father's Name (First, Middle, Last) Israe1 S	18.Mother's Name (Unk)	(First, Middle, Ma	iden Surname)								
	S S	19a. Informant's Name/Relationship (Type, Print)	reet and Number or R		er, City or Town, State,								
O 4 4 4 4		David Singer / Son 20a. Method of Disposition	Date Z	MD 208 20c. Location - City or									
Baltimore, permit. Pages 1 an Department of He. Important: If ite		4 Donation 5 Other Specify:	Burial 2 Cremation 3 Removal from State crematory or other place) Chos appeals Crematory 03/22/2012 Belts										
Baltimore, MI permit. Pages 1 and 2 a Department of Health a Important: If item 27	- 1	21. Signature of Funeral Source Meensee	Signeture of Funeral Service Mensee Moo382 Rapp Funeral and Cremation Service 933 Gist Ave. Silver Spring MD										
Physician /Medical	7	 Part I. Enter the disease, or complications that failure. List only one cause on each line. 	caused the death. Do	o not enter the mode of dyir	ng, such as cardiac or	respiratory arres	t, shock, or heart	Approximate Interval Between Onset and Death					
Examiner			erotic Cardiovas a consequence of):	scular Disease									
	je l	Sequentially list conditions, if any, leading to immediate eques. Enter U. dortwing Course	a consequence of):										
ted nsit	Examine	(Disease or injuny that initiated C.	a consequence of):										
60, ate be executed hysician and he burial - transit	Medical	UNPENDED AMENDED)				350 500						
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit		23b. Was decedent pregnant in the past 12 months?	s, outcome of pregnar birth gnant at time of death nown	2 Fetal death	3 Ectopic pregna			oay Year					
P.O. E	2	Part II. Other significant conditions contributing	to death but not resu	ulting in the underlying caus	se given in Part I.		acco use contribute to						
Division of Vital Records, P.O. Box 6876 To the Hospital or Attending Physician: The law requires that the death certifical within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the	Completed					24a. Was ar autopsy perform 1 Yes 2	prior to death?	topsy findings available completion of cause of second 2 No					
/ital rsician:	å	25. Was case referred to medical examiner? 1 ✓ Yes 2 No	Inpatient 2 E	26.Pl	Other Nursin		esidence 6 🗸 Other	: Scene					
in of \india of	ion: To		te of Injury hth, Day,Year)		njury at Work?	28d. Describe ho	w injury occurred						
Division To the Hospital or Attent within 24 hours after death To the Funeral Director:	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined (Special		ne, farm, street, factory, offic	ce building, etc.	28f. Location (St or Town, Sta		iral Route Number, City					
the Hospita in 24 hours the Funera	Medical Ce	4 Homicide 29a. Certiffer 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the											
To the within To the comple	Med	29b. Signature and title of certifier		29c. Lic	ense number	T	29d. Date signed (Mo						
		30. Name and address of person who completed c	ause of death (flem)		C.M.E. 		March 19, 2012						
12+11		Zabiullah Ali, M.D. Assistant Med	lical Examiner V	900 W. Baltimore S	treet, Baltimore,	MD 21223							
St	ate	31. Date filed (Month, Day Year) 32.	Registrar's Signature	wen									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / Department of Health and Mental Hygiene													
			State Registrar	Cert	tificate of D	eath		g. No.	2 19170							
	Physicia	n/	1. Decedent's Name (First, Middle, Last)				Date of Death Month	Day Yes	NA I							
	Medic	al		SINGLETON		Landler of Doobh	March	17 2012								
	Examin	er	4a. Facility Name (if not institution, give street and number)	,	4b. City, Town, or BALTI			4c. County of D	Death							
	Funeral		GOOD SAMARITIAN NURSING HOME 5. Social Security Number 6. Sex 7. Age (In yr.	rs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	9.	Birthplace (State or Foreign							
	Director		217-34-9430 ¹□м 2X☐F	83 Yrs.	Months Days	Hours Min.	(Month, Day, SEPT 2	^{Year)} 1928	Country) MARYLAND							
	wo		Usual Residence of Decedent						10d. Inside City Limits							
	yland -f show ed at	cto		City, Town or Loc					1 X Yes 2 □ No							
	r 28a notifi	Director	MARYLAND N/A 10e. Street and Number		10f. Zip Code	<u>ALTIMORE</u>		0g. Citizen of Wha								
	ith th	rall			2120	6	,,	U.S.A.								
	ath w	Funeral	5725 WHITE AVENUE 11. Marital Status 12. Was Decedent Ever in	U.S. 13. W	Vas Decedent of His	spanic Origin? (Sp	ecify Yes or No-		American Indian,							
٥	or its	by F	Armed Forces? 1 □ Never Married 2 □ Married 1 □ Yes 2XX No		Yes, specify Cubar		Rican, etc.)		Vhite, etc.							
3	ırs afi ural", IExa		3X Widowed 4 □ Divorced If Yes, Give Year or Dates.		Yes 2 X No	Specify:		Specify: BI	LACK							
ດ້	2 hou "nat	ple	15. Decedent's Education (Specify only highest grade completed)	[(Give k	lent's Usual Occupa and of work done d	ation uring most of work	ring	16b. Kind of Busin	ess Industry							
7	thin 7 sne. than he M	Completed	Elementary/Seconday (0-12) College (1-4 or 5+) 12yrs 6yrs		O NOT use retired) CHER			EDUCAT	TON							
Z D	ould be filed within 72 hours after death with the Maryland of Mental Hygiene. The marked other than "natural", or items 23a or 28a-f sho marked other than "natural", or items 23a or 28a-f sho marke other, the Medical Examiner must be notified at matic event, the Medical Examiner must be notified at	Be (17. Father's Name (First, Middle, Last)	ILAC	Juek	18. Mother's Nam	ne (First, Middle, M		ION							
ā	be fil ental rked ic ev	မ	NATHANIEL WILSON			ELTZAB	ETH SMIT	H								
a	2 should be file Ith and Mental I 27 is marked o traumatic eve		19a. Informant's Name/Relationship (Type, Print)	19b. Mailin	g Address (Street a				e, Zip Code)							
Σ			Melissa Singleton/ Daughter	5725	5 White A	venue, B	altimore	, Marylar	nd 21206							
e C	ge 1 and 2 it of Healt If item 2 or other		20a. Method of Disposition 1 ☐ Burial XX Cremation 3 ☐ Removal from State	b. Place of Dispos cemetery, crem	sition (Name of natory or other place	θ)	Date	20c. Location - Cit	y or Town, State							
Ĕ	Page ment o tant: If lury or		4 Donation 5 Other (Specify)	METRO CRI	EMATORY	03-2	0-2012	BALTIMORI	E, MARYLAND							
Baitimore, maryland 21215-0036	permit. Page Department Important: I any injury o		21. Signature of Four Survivales Communications of Survivales	22. V	Name and Addres WILLIAM C 1206 W NO	s of Facility BROWN C RTH AVEN	OMMUNITY UE	FUNERAL	HOME P.A.							
			23a. Part 1. Enter the disease, or complications that caused the d shock, or heart failure. List only one cause on each line.	Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,												
	nysician/		Immediate Cause (Final disease or condition Mediate (Final disease	tasta	tic (LUION	Cano	en	Interval Between Onset and Death							
	Medical Examiner		resulting in death) a. Due to (or as a cons	sequence of):												
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P.O. Box 68/	death ne attr ed for	sici	1 Yes 2 No 4 Pregnant at time		Other (specify)			Month	Day Year							
	it the by the	Phy	9 Unknown Part II. Other significant conditions contributing to death but not	t resulting in the u	inderlying cause giv	en in Part I.	23e Did tob	acco use contribut	te to the cause of death?							
7.	es tha	l by	None		, , ,				Probably 4 2 biknown							
g	requir seen s hould	etec					24a. Was ar	24b. Wen	e autopsy findings available							
ဝင္ပ	sician: The law r certificate has b irector, page 2 sl	Completed					autops perforr	y prio deat	r to completion of cause of th?							
ř	n: The fficate or, pag		25. Was case referred to medical		26. Pla	ace of Death (Chec	1 Yes 2	No 1 L	Yes 2 No							
Z	/sicia s cert direct	To Be	examiner? 1 Yes 2 No Hospital:	ER/Outpatien	nt 3 🗆 DOA Othe	er: 4 🖳 Nursing H	ome 5 🗆 Reside	nce 6 Other (S	Specify)							
o	g Physer thi		27. Manner of Death 1 ☑ Natural 5 ☐ Pending 28a. Date of injury (Month, Day, Year	28b. Time of		/ at	28d. Describe ho	w injury occurred								
on	endir eath. or: Af the fui	fica	2 Accident Investigation	2 Accident Investigation M 1 Yes 2 No												
Division of Vital Records,	al or Attending Pl s after death. Il Director. After the ed in by the funeral	Certificate:	4 Homicide determined 28e. Place of Injury - A building, etc. (Spe	t home, farm, stre ecify)	eet, factory, office		28f. Location (Str City or Town		r Rural Route Number,							
Ξ	pital ours a eral D		29a. Certifier 1 Certifying Physician: To the best of my kr	nowledge death (occured at the time.	date and place, a	nd due to the caus	se(s) and manner a	s stated.							
	To the Hospital or Attending Physician: The law requires that the death certificate I within 24 hours after death. To the Funeral injector. After this certificate has been signed by the attending phys To the Funeral injector. The funeral director, page 2 should be detached for use as the completed filled in by the funeral director, page 2.	Medical	(Check 2 Medical Examiner: On the basis of examiner only one) 3 Certifying Nurse Practioner: To the best of	ation and/or invest	tigation, in my opinio	on, death occurred a	at the time, date and	d place, and due to	the cause(s) and manner stated.							
	Voithir Comp	2														
	1		Jenous Ch	an My	D	2871	U	March	4/1,2012							
	11		30. Name and address of person who completed cause of death (Item 23a) (Type, P	Print)	///	1 42	Klud	Month, Day, Year) 17,2012 Baltimore							
	1		31. Date filed (Month; Dey, Year) 32. P. 32. P. 33. P. 34.	ignature	2601	count		<u> </u>								
	Sta Registr		31. Date filed (Month, Dey, Year) 32. R Islands Si	griature.	all											

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amend #10a-f, per fh, 2928 6-14-12 sm
State of Maryland / Department of Health and Mental Hygiene

		1	For State Registrar	Otato of Maryland		rtificate of	Death)		Reg. No.	12	09127		
	Physicia		1. Decedent's Name (First, Middle, La						2. Date of Dea	20, Day 20:	Year	3. Time of Death		
	Medic	al .	DAVID MANUI 4a. Facility Name (if not institution, give			4b. City, Town,	or Locatio	n of Death	MARCH		ty of Death	9:02 P ^M		
	Examin	er	GILCHRIST HOSP			TOWS					BALTIN	10RE		
П	Funeral		5. Social Security Number 6. S	Sex 7. Age (In yrs. las	st birthday)	If Under 1 Year Months Day		er 24 Hrs, Min.	8. Date of Birt		9. Birthp Coun	olace (State or Foreign try)		
	Director		214-66-6366 Usual Residence of Decedent	M 2 □ F 56	Yrs.				11/06/	06/1955 MD				
	and show lat	o	10a, State 10b, County	10c. City,	Town or Lo	Reho	beth	Beach			1	0d. Inside City Limits		
	Maryl 28a-f otifiec	Director		IMORE -0	WINGS	MILLS						1 ☐ Yes 2 🔀 No		
	within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notifiled at			mbridge Way		10f. Zip Code	117	971		10g. Citizen of	f What Cour	itry?		
	ath wi	Funeral	435 WOODHILL DR	12. Was Decedent Ever in U.S.	13.	Was Decedent of If Yes, specify Cu	Hispanic	Origin? (Spec	oify Yes or No-	USA 14. Ra	ace - Americ	an Indian,		
9	or ite	by F	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 X No		If Yes, specify Cu			Rican, etc.)		ack, White,	etc.		
8	urs af tural" al Exa	ted	3 Widowed 4 X Divorced	If Yes, Give Year or Dates.						Specia	WI	HITE		
15-	72 ho n "nai Aedici	Completed	15. Decedent's (Specify only highest g	rade completed)	(Give	dent's Usual Occ kind of work don OO NOT use retire	e during m	ost of workir	g	16b. Kind of	Business/in	dustry		
212	within giene, er tha , the N	ပိ	Elementary/Secondary (0-12)	College (1-4 or 5+)	SA	LES				R	ETAIL			
nd	be filed ental Hy ked oth ic event	To Be	17. Father's Name (First, Middle, Last)						(First, Middle,	Maiden Surnar				
Ŋ	should be filk and Mental ' 7 is marked or raumatic eve		SIDNEY	SHERMAN		ing Address (Stre	_	JTH	Pouto Numbo	or City or Town	BABI			
Maryland 21215-0036	12 shoulth and 27 is a	1 1	19a. Informant's Name/Relationship (KARL ZORIC/PART)			5 WOODHI								
	1 and of Hea item		20a. Method of Disposition	20b. Pl	ace of Disp	osition (Name of matory or other p		5	ate	20c. Location				
imo	Page ment o ant: If ury or		1 XBurial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Spec	ify) BAL	TIMOR	E HEBREV	CEM					OWN, MD		
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral S	see		2. Name and Add								
	407.00	Н	23a. Part 1. Enter the disease, or con	nplications that caused the death		8900 REI					ا وظامانا	Approximate		
	Pnysician/		shock, or heart failure. List only Immediate Cause (Final	one cause on each line.	1000	can						Interval Between Onset and Death		
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68760	artifical ding ph	/Me	IF FEMALE:	23c. If yes, outcome of pregnal	ncv					024 [Date of d eliv	on.		
Box (The law requires that the death certi rate has been signed by the attendin page 2 should be detached for use	Physician/N	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	1 Live Birth 2 Feta 4 Pregnant at time of d	death 3	☐ Ectopic pregn☐ Other (specify,					Month	Day Year		
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, P.O.	s that igned be def	by	Part II. Other significant conditions	contributing to death but not res	ulting in the	underlying cause	given in P	art I.	1			he cause of death?		
rds	require	eted							24a, Was			ppsy findings available		
eco	law has ye 2	Completed							auto perf	opsy orm ed ?	prior to co death? 1 \square Yes	ompletion of cause of		
a R	ician: The certificate rector, pag	Be C	25. Was case referred to medical			26	. Place of I	Death (Check	1 L Yes	FINOI	1 🗆 163	2010		
Vit	hysician: this certific al director,	10 E	examiner? 1 Yes No	Hospital: 1 Inpatient 2		ent 3 L DOA	Other: 4 [idence 🛵 O		, hospice		
lof	d ing Ph h. After th funeral		27. Manner of Death Natural 5 Pending	28a. Date of injury (Month, Day, Year)	28b. Time injury	- W	ijury at ork? ☐ Yes :2	_ {	28d. Describe	how injury occu	urred			
Sior	or Attending Physician: after death. Director: After this certific I in by the funeral director,	Certificate:	2 ☐ Accident Investigati 3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	be 28e. Place of Injury - At ho					28f. Location (Street and Nun	nber or Rura	i Route Number,		
Division of Vital Records,	s after s after al Dire			building, etc. (Specify						wn, State)				
	Hospital or 24 hours afte Funeral Dir	Medical	(Check 2 Medical Exa	ysician: To the best of my knowl miner: On the basis of examination	and/or inve	estigation, in my or	pinion, deat	h occurred at	the time, date	and place, and	due to the ca	ause(s) and manner stated.		
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	ž	only one) 3 Certifying Nu 29b. Signature and title of certifier	rse Practitioner: To the best of n	ny knowledg		ense numb	er		29d. Date sign	ned (Month,	Day, Year)		
			Monard	m) 58	3307	<u> </u>	MAL	crt 2	1 2012		
	13 8mg		30. Name and address of person who	ANUES M) (201	M. CL	ion (s	72	Tows	0~~	2			
	Sta Registr		31. Date filed (Month, Day, Year) NAR 2 3 2012	32. Registraris Signa	alla									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** David Carl Tolbert MARCH 2012 /Medical 4c. Coupty of Death 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or bocation of Death Examiner WERSIN 8. Date of Birth (Month, Day, Year) 07/28/1931 Birthplace (State or Foreign Country) If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months Hours Min XXM 2□ F 225-34-6058 80 Yrs Virginia Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f shown may Injury or other traumatic event, the "Modral Evantion," and the notified at once. 28a-f show 1 ☐ Yes XX No Director Maryland Harford County Edgewood 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1225 Paul Martin Drive 21040 United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 X Married 1951-1 ☐ Yes 2 🛛 No Specify. Specify: White ģ 3 Widowed 4 Divorced 1954 Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 12 Construction Construction 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Daisy L. Horton George E. Tolbert 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3140 Rocks Chrome Hill Rd., Jarrettsville, MD 21084 Pamela Haslam (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Evans Funeral Chapel 03/21/2012 Forest Hill, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Evans Funeral Chapel & Cremation Services-BelAir Newport Drive, Forest Hill, Maryland 21050 3 Approximate Interval Between Onset and Death 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) wonis /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of, Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 5 ☐ Other (specify) signed by the a 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ≥ 1 Yes 2 🗆 No 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an s certificate has the inector, page 2 standard autopsy performed? Yes 2 No 1 ☐ Yes director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one. Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ို 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of 27. Manner of Death Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Matural 1 ☐ Yes 2 ☐ No 2 Accident after death

Director: , 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide in 24 hours the Funeral Dire 1 Cretifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical completely

within 2

timore, Maryland 21215-0036

Bal

Division of Vital Records, P.O. Box 68760,

State Registrar 29b. Signature and title of certified

31. Date filed (Month, Day,

29c. License number

29d. Date signed (Month, Day, Year)

and manner stated.

6

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

12-02157 Margaret Tully

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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Physician	/ 1	. Decedent's Name (First, Middle			T 11				2. Date of Dee Month	Dev Year	3. Time of Death 1520 hrs			
Medical Examine		la. Fecility Name (if not institution	Margar , give street and num	et Mary ber)		4b. City, T	own, or Lo	ocation of Dea	March 15,	4c. County of				
		8821 Blairwood Road,				Nottin	gham			Baltimore				
Funeral Director	5	and the second		. Age (In yrs. la		If Unde	r 1 Year Days	If Under 24H Hours M	in		9. Birthplace (State or Foreign			
Director	Ļ		1 M 2 F	62	Yrs). <u> </u>			06/0	2/1949	Counteryland			
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the Maryland or 28s-f sh	1	10e. Street end Number	J A 4 A 1			10f. Zip	Code	21236	1	0g. Citizen of Whe	t Country? USA			
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or items 23		1 Never Married 2 Ma						Mexican, Puer		White,	etc.			
ral", o			rced If Yes, Give Yaar or Dates:		1 🗆		No No		formalis dans	Specify: 16b. Kind of Busi	White			
5-0036 ed within 72 hours aft ed within 72 hours aft other than "natural" he Medical Examina	3 -	15. Decedent's Education (Spec Elementary/Secondary (0-12)	ify only highest grade					n (Give kind o						
O36 rehin 73		12					Secre	etary		Telec	ommunications			
Hygie Willed wi		17. Father's Name (First, Middle,	Last) William B.	Tully			18	3.Mother's Nar		Maiden Surname) othy Ruth Re	ad			
21215-0036 tould be filed within 7 d Mental Hygene. is marked other than tie event, he Mester		19a. Informant's Name/Relationsh		Turry	19b. Mailin	g Address	(Street	and Number o		nber, City or Town,				
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Merkent Francian must be neithed at tone. To Be Commissed by Firmeral Director	1	Donald K. Tully / Br	other			-			lilton, FL 32					
or free of the fre		20a. Method of Disposition 1 Burial 2 Cremation	Burial 2 Cremation 3 Removal from State crematory or other place) Chesapeake Crematory 3/23/2012											
Baltimore, permit. Pages 1 ar Department of Hes Important: If ite	L	4 Donation 5 Other Sp	ltsville, MD											
Ball permit Depar injury	T	21. Signature of Funeral Service I	7 1 1000											
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Division of Vital Records, P.O. spital or Attending Physician: The law requires that the hours after death. Meral Director: After this certificate has been signed by ifilled in by the funeral director, page 2 should be detacted.	Certification:		d not be 20e. Place mined (Specify)	or injury - Acri	ome, rarm, sire	et, ractory	, onice oc	many, etc.	or Town,		of Naral Notes Namber, Only			
15 P		29a. Certifier 1 Certifying Ph	ysician: To the best	of my knowled	ge, death occu	urred at the	time, dat	e and place, a	nd due to the cau	se(s) and manner	as stated.			
To the comple	밌		miner: On the basis of and manner sta	f examination a ated.	and/or investiga				d at the time, date					
• ·		29b. Signature and title of certifie				296	c. License O.C.N			March 16, 2	d (Month, Day, Year)			
	-	30. Name and address of person	1	e of death (Item	1 23a)									
V		Ling Li, MD Assista	nt Medical Exam	niner 900	W. Baltimo	re Stree	et, Balti	more, MD	21223					
Sta Registra	te ar	31. Date filed (Month, Pay Year)	2012 32/Rec	gistrar's Signat	. pa	Kar								
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year 20 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Genesis Perring Parkway Baltimore Parkville Date of Birth (Month, Day, Year) Aug 13, 1921 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) 1 M 2 M Months Days Hours Min. West Virginia 407-30-8832 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County MD 1 ☐ Yes 2 ☐ No Baltimore Middle River 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21220 United States 1618 Burke Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Specify. Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Accounting Clerk Construction 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Beverly Randolph Ricketts Spicie Brinegar 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sanders /Son Charles 1618 Burke Road Middle River, MD 21220 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Mar 21 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Beltsville, Maryland 2012 Chesapeake Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name matrice not andy Funeral Alternatives 21. Signature of Funeral Service Licensee 8717 Green Pastures Drive Towson Maryland 21286 23a. Part 1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final HRONIC OBSTRUCTIVE LUNG DISEASE disease or condition resulting in death) Due to (or es a consequence of): DEMENTIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐Yes 2 ☑No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 🗌 No 3 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? Colon 24a. Was an autonsy perform 2 No 2 Was case referred to medical examiner? 1 ☐Yes 1 ☐ Yes 26. Place of Death (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury at Work?

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

r than "natural", or items 23a or 28a-f show the Medical Evaniner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after death with t. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 2 any linjury or other traumatic event, the Medical Exercises 200.00.

Director

Funeral

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Completed

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Examine cate has been signed by the attending physician and page 2 should be detached for use as the burial-tran Physician/Medical ģ Completed certificate has within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, I Be Certification: To

Hospital or Attending Physician: The law requires that the death certificate be executed

the

P

Division of Vital Records, P.O. Box 68760,

1 Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury

28d. Describe how injury occurred

1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of contifier

5 Pending investigation

6 ☐ Could not be

determined

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 821 Maria

State Registrar

Medical

31. Date filed (Month, Day, Year) MAR 2 3 2012

2 Accident

4 Homicide

3 Suicide

29a, Certifier

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Physician/ 20 8:41 John B. Terwilliger March D Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 1330 Chippendale Road Baltimore Lutherville 8. Date of Birth (Month, Day, Nov. 14. 9. Birthplace (State or Foreign Country) New York If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Social Security Number 7. Age (In yrs. last birthday, **Funeral** Months 107-22-7664 1929 Director Jsual Residence of Decedent or 28a-f show be notified at 10c. City, Town or Location 10d. Inside City Limits 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant If item 27 is marked other than "natural", or items 23a or 28a-f sho Completed by Funeral Director MD 1 🗌 Yes 2 🛶 No Baltimore Lutherville 10f. Zip Code 10e. Street and Number 10g, Citizen of What Country? ms 23a or must be r 1330 Chippendale Road 21093 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11. Marital Status Examiner Black White etc 1 Yes 2 No If Yes, Give 1954— Year or Dates. 1956 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ▼ No Specify: Specify: White 3 Divorced and Mental Hygiene.
is marked other than "natur aumatic event, the Medical! 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Music Educator Towson University Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Benjamin Hasbrouck Terwilliger Grace Maxine Collins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wanda R.Terwilliger/wife 1330 Chippendale Road Lutherville MD. 21093 injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date permit. Page 1 a
Department of F
Important: If ite
any injury or oth 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 3/22/12 Metro Crematory Inc. Baltimore Maryland 21. Signature of F neral Service License Stephanie Custer 22. Name and Address of Facility Cremation Society of MD. Inc. 299 Frederick Road Baltimore,MD.21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition Gliobasloma Physician Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or iinjury that initiated events burial-trar Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23d Date of delivery 23b. Was decedent pregnant Live Birth 2 - Fetal death 3 Ectopic pregnancy in the past 12 months? Month Pregnant at time of death 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 📉 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy 1 Yes 2 No Yes After this certificate 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Other: 4 \square Nursing Home 5 \bowtie Residence 6 \square Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA မှ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: 28c. Injury at 5 Pending 1 Natural 1 Yes 2 No 2 Accident
3 Suicide Investigation within 24 hours after death

To the Funeral Director: completed filled in by the 6 Could not be 28f. Location (Street and Number or Rural Route Number, 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the within 2 To the F only one) 29d. Date signed (Month, Day, Year) 29c. License number March 2187 2012 D72139 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Suil 4105 Baltimore, MD 21204

Registrar DHMH 17 Rev 7/2009

State

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Charles

12-02296

Tina Ulloa - Martinez

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2-02296 'ina Ulloa - Martine		Please Type or Print in Black Indelible Ink. Ensure All Copies State of Maryland / Department of Health and Mental Hy	giene	ible.										
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riedicai Examine	1	Tina S. Ulloa - Martinez a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death	IVIATOR EG, E	4c. County of Deat	h									
		Baltimore Washington Medical Center Glen Burnie		Anne Arunde										
Funeral Director	1	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. Months Days Hours Min.	8. Date of Birth 2 / 1 4 /	(MM/DD/YYYY) 9. Bi Forei 1 0 7 9 Co										
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r death with or items 23 must be no		1. Marital Status 1. Marital Status 1. Was Decedent Ever in U.S. 1. Never Married 2. Married Armed Forces? 1. Never Married 2. Married Armed Forces? 1. Marital Status 1. Was Decedent of Hispanic Origin? (Specific Specific Specif		White, etc.	rican Indian, Black,									
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Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f sho injury or other traumatic event, the Medical Examiner must be notified at once. TO Be Completed by Funeral Director	-	Donna K. Oxendine / Mother 1117 East Riversion												
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transitical Certification: TO Be Completed by Directorian/Medical Expedical Control of the contr	ا د	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and	due to the cause	(s) and manner as sta	ated.									
To the Hos within 24 h To the Fur completely		one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred a and manner stated.	t tne time, date a											
	Ē	29b. Signature and title of certifier 29c. License number		29d. Date signed (M March 21, 2012	· · · ·									
		Och.E. O.C.M.E.		March 21, 2012										
		30. Name and address of person who completed cause of death (Item 23a) Victor Weedn MD JD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore	re. MD 2122	3	Į									
Stat	ii ta		,											
Registra	ar	31. Date filed (Month, Day, Year) MAR 2 3 2012												

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MARCH 19, 2017 1542	27	hin 72 hours after death with the Maryland	rle. than "natural", or items 23a or 28a-f show ie Medical Examiner must be notified at
SHINE	1215-0036	hin 72 hours after de	ne. than "natural", or it e Medical Examine

For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death ian/ March 2012 3:00 PM Lillian Stadol Varshine ical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) ner Montgomery Rockville Shady Grove Adventist Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 6. Sex 7. Age (In yrs. last birthday) (Month, Day, Months Hours Min. 1 M 2 X Pennsylvania 198-22-2131 84 March ľ928 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 X Yes 2 No Maryland Rockville Montgomery 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral United States 20850 9701 Veirs Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify. Specify: White Completed 3 X Widowed 4 □ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker permit. Page 1 and 2 should be filed with Department of Health and Mental Hygier Important: If item 27 is marked other t any injury or other traumatic event, th Saltimore, Maryland 2 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Susie Vozar John Stadol 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 104 Water Street, Gaithersburg, Maryland 20877 Sonny Varshine / Son 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of March 21, cemetery, crematory or other place) 1 Durial 2 X Cremation 3 Removal from State Bethesda, Maryland Montgomery Crematorium, Inc. 2012 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 Busul Jageletes M01305 23a. Part 12 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval-Between Onset and Death Immediate Cause (Final tailure Physician/ respiratory disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner neumonia Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury myocardial non ST elevation and use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 attending p for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year ed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by s been signe should be c 1 Yes 2 No 3 Probably 4 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? cancer 24a. Was an preast autopsy page 2 dinbetes melitus 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner?
1 \(\sum \) Yes 2 \(\overline{\pi} \) No Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Hnpatient 2 ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 27. Manner of Death 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be within 24 hours after death

To the Funeral Director,
completed filled in by the 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number ٩ ô 8m 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ,00 Center Drive, Folkville, Medical 9901 Donn 31. Date filed (Month, Day, Year) **MAR 2 3 2012** 32. Registrar's Signatur State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		-	ForState	State of Ma	•		tment of H ficate of D		and M	ental Hy		0.0.1	0 /	20101	
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	Funeral Director		5. Social Security Number 6. Se 070-26-6104	X M 2 \square F	e (In yrs, last birth	M	Months Days	Hours	Min.	8. Date of Bir (Month, Da		9. Bi	nthplace (Sountry)	State or Foreign	
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	is filed within 72 hours after death with the Maryland ital Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	ral	14805 Pennfield	Cir. #212			209	906			-	ited St		3	
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E	Page 1 ment of ant: If it ury or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif		I .				03/21	1/2012	Be1	tsville	e, MI)	
Baltimore, Maryland	permit. Page Department of Important: If any injury or once.		21. Signature of Fundral Service Licens												
			23a. Part 1. Enter the disease, or comp shock, or heart failure. List only o	plications that caused	the death. Do n							110		oximate val Between	
~ .	Physician/	en a	Immediate Cause (Final disease or condition		NARY FI	BROS	IS							et and Death	
	Medical Examiner		resulting in death)	Due to (or as	a consequence o	of):									
		er	Sequentially list conditions, if any, leading to immediate	b. Due to (or as	a consequence of	of):									
	ted I	Examiner	Cause (Disease or injury	_	, , , , , , , , , , , , , , , , , , , ,	,									
	execu an and irial-tra	EX	that initiated events resulting in death) Last	Due to (or as	a consequence of	of):									
09	cate be executed physician and s the burial-transit	edical		d									-		
P.O. Box 68760	entifica ding p	/Me	IF FEMALE:	23c. If yes, outcome	of pregnancy							23d. Date of de	aliven		
X	atten	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	1 ☐ Live Birth 4 ☐ Pregnant a	2 Fetal death		ctopic pregnanc Other (specify)	У				Month	Day	Year	
В	the de by the tached	hys	9 Unknown	9 🗀 Unknown											
т. О	es that signed I be de	by	Part II. Other significant conditions of	ontributing to death b	ut not resulting i	n the und	lerlying cause glv	en in Par	t I.			se contribute t		se of death?	
Division of Vital Records,	requir been s	Completed								24a, Was				dings available	
ecc	e has	dwc								auto	psy ormed? 24 No			on of cause of	
ai H	ian; Th	Be C	25. Was case referred to medical examiner?				26. Pla	ace of De	ath (Check		244 INC	1 1 10			
<u> </u>	hysici his ce al direc	၉	1 ☐ Yes 2 💢 No	_	ent 2 ☐ ER/Ou			4 L I				Other (Spe	cify)LTV	TISTED TING	
l of	ing P	ate:	27. Manner of Death 1 X Natural 5 □ Pending	28a. Date of inju (Month, Da		Fime of njury	28c. Injury work M 1 🗆	/ at ? Yes 2 [- 1	28d. Describe	how injury	occurred			
Siol	Attend r death ctor: by the	Certificate:	2 Accident Investigation 3 Suicide 6 Could not b 4 Homicide determined	28e. Place of Inju		rm, street		163 21				Number or R	ural Route	Number,	
Ω	tal or a safte al Dire		4 E Horniode determined	building, etc	c. (Specify)					City or To	wn, State)				
-	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending prompletely filled in by the funeral director, page 2 should be detached for use as	Medical	(Check 2 Medical Exam	sician: To the b of of iner: On the	xa ation and/o	or investiga	ation, in my opinio	n, death	occurred at	the time, date	and place,	and due to the	cause(s)	and manner stated.	
	o the orthon of the orthon orthon	Ž	only one) 3 L Certifying Nur 29b. Signature and title of certifier	se Practitioner: To the	e sest of my know	wiedge, de	29c. License	number	ate and plac	ce, and due to		s) and manner e signed (Mon		ear)	
	->-0				WY D)	D474	447			M	ARCH 1	9, 20	012	
	20,1		30. Name and address of person w/o	//	eath (Item 23a) (
	0	() (ANDREW LAZRIS M. 31. Date filed (Month, Day, Year)	/ /			#103, CO	OLUM]	BIA, N	MD 21	1044				
	Sta Registr		MAR 2 3 2012	Zerras A	's Signature										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1	State of Maryland	/ Department (ental Hygien	6 U I 6	09135
			Registrar 1. Decedent's Name (First, Middle, Last)			2. Date of Death		3. Time of Death
	Physicia		Paul A. Witte	J	1	Month 19	ay 2012	9:00 A ^M
,	/Medic		4a. Facility Name (If not institution, give street and number)	4b. City, To	own, or Location of Death	IGICII	c. County of Deat	h
	Examin	er	Holy Cross Hospital	S	ilver Spring		Montgo	omery
	Funeral		 Social Security Number Sex Age (In yrs. last 	st birthday) If Under 1		B. Date of Birth (Month, Day, Yea	9 Rint	hplace (State or Foreign
	Director		218-54-9638 ¹ 2 M ² F 57	Yrs.		June 8, 19	54 Mar	cyland
	9	- 1	Usual Residence of Decedent	Town or Location				10d. Inside City Limits
	show	. 1	100.000		er Spring			1 ☐ Yes 25 No
	8a-f	Director	MD Montgomery	10f. Zip C		10g. C	Citizen of What Co	ountry?
	with the	吉	10e. Street and Number 3944 Pel Pre Rd. #4	101. 240	20906		nited Sta	
	s 23	era	331, 101 110	. 13. Was Decede	nt of Hispanic Origin? (Spec y Cuban, Mexican, Puerto F		14. Race - Ame	nican Indian,
_	irer.	Funeral	Armed Forces?			tican, etc.)	Black, Whit	
20	hours after death with the Maryland turel; or Items 23a or 28a-f show LExuniter must be notified at	þ	If Yes, Give → Year or Dates:	1 ☐ Yes 2 [X № Specify:		Specify: V	White
9500-61212	72 hours after death w "naturel", or Items 23a colc Exc. in at real t	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual	Occupation done during most of working	a 16b.	Kind of Business	/Industry
2	within 72 ene. then "nat	ple	Elementary/Secondary (0-12) College (1-4or 5+)	life. DO NOT use	done during most of workin retired)	1		.m. Woulding
	be filed within 72 ho lal Hygiene. d other then "natur event, ire Modic	Col	12	Maintenanc		(First, Middle, Maide		ım Housing
<u>n</u>	d be fill intal H ed oth	Be	17. Father's Name (First, Middle, Last) Donald M. Witte	ers	Francis	L.		G1en
Maryiand	should nd Men s marke umetic	၉			Street and Number or Rura	Route Number City	v or Town. State.	Zip Code)
<u>a</u>	C/ cg 75 00	H	19a. Informant's Name/Relationship (<i>Type</i> , <i>Print</i>) Donald M. Witters, Jr. / Brothe		dar Creek Ln			
	1 and Health em 27	1 4	20b. Pia	ice of Disposition (Name	of D		Location - City or	
٥			1 D wint a WCtion 2 D amount from State	metery, crematory or oth sapeake Cre	matory 03/2	3/2012	Beltsv:	ille, MD
Baltimore,	permit. Page Department of Importent: If any injury or once.	-	21. Signature of Eu eral) e Licensee	-	Address of Facility neral and Cre			
æ	Dep Imp		1 Dronne	Rapp Fu	neral and Cro t Ave., Silve	emation Se er Spring	ervices MD 20	910
			23a. Part1. Enter the disease, or complications that caused the death.					Approximate Interval Between
ia.	Physician		shock, or heart failure. List only one cause on each line. Immediate Cause (Final	CADDIAI INE	'A DTTON			Onset and Death 1 HOUR
	/Medical		disease or condition resulting in death) a. ACUTE MYO Due to (or as a consequence)	CARDIAL INF ence of):	AKTION			1 HOOK
F	Examiner		Sequentially list conditions b. CORONARY	ARTERY DISE	ASE			UNKNOWN
	D ==	ner	if any, leading to immediate cause. Enter Underlying	ence of):				
	acute ind trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last c. DIABETES Due to (or as a consequence of the consequ	once of:				UNKNOWN
760,	ate be executed rysician and he buriat-transit	cal E)	RENAL FAI					UNKNOWN
687	physic the l		d					
	leath certificat attending phy I for use as th	/Me	IF FEMALE: 23c. If yes, outcome of pregnant				23d. Date of de	olivery
Box	The law requires that the death certifica tte has been signed by the attending ph page 2 should be detached for use as it	by Physician/Med	in the past 12 months? 4 Pregnant at time of de				Month	Day Year
o.	that the de ed by the detached	hys	9 Unknown			_		
<u>ر</u> م	es that igned to be det	y P	Part II. Other significant conditions contributing to death but not resu	lting in the underlying ca	use given in Part I.			to the cause of death?
rd	v require been sig should b		HYPERTENSION			1 🗆 Yes	2 No 3 P	Probably 4 XIUnknown
Records,	e law re has be je 2 sho	Completed				24a. Was an autopsy	prior to	utopsy findings available completion of cause of
		Com				performed 1 ☐ Yes 2 🔀	? death? No 1 ☐ Ye	s 2 No
Vital	ician: The certificate rector, pag	Be (25. Was case referred to medical examiner?		26. Place of Death			
of/	Physician: r this certific ral director,	မ	A	ER/Outpatient 3 DO/ 28b. Time of 28		me 5 Residence 28d. Describe how in		ecify)
	tending Physician: eath. tor: After this certific the funeral director,	lon	27. Manner of Death 1 X Natural 5 ☐ Pending (Month, Day Year) 2 ☐ Accident investigation	Injury M	3c. Injury at Work? 1 ☐ Yes 2 ☐ No		,,,	
Sic	l or Attending after death. Director: After In by the fune	icat	3 Suicide 6 Could not be 28e Place of Injury - At hor	me, farm, street, factory,		28f. Location (Street	and Number or F	Rural Route Number,
Division	lor A after Direction by	Certification;	4 Homicide determined building, etc. (Specify)		City or Town, S	ate)	
_	To the Hospitel or Att within 24 hours after of To the Funerel Direct completely filled in by		29a. Certifier 1 Certifying Physician: To the best of my know (Check only 2 Medical Examiner: On the basis of examinat	wledge, death occurred a	at the time, date and place,	and due to the cause	e(s) and manner a	as stated.
	n 24 I n 24 I he Fu	edical	(Check only 2 Medical Examiner: On the basis of examinat and manner stated.					
	To the within 2 To the complet	Ž	29b. Signature and title of certifier	29c.	Danse number		Date signed (Mor	
•	1		"Claven / Onego		D38435		MARCH 19	, 2012
	121		30. Name and address of person who completed cause of death (Item		TIME DO			0010
	10		AARON E. KENIGSBERG, M.D.; 150 31. Date filed (Month, Day, Year) 32. Regignar's Signar	JU FOREST GI	LEN RD., SILV	EK SPRING	, MD 2	0910
	St Regist	ate rar	31. Date filed (Month, Day, Year) NAR 2 3 2012 Share Signal	Ver				
		**	WALL OF THE PROPERTY OF THE PR					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death L. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day Month 9:55 AM illiams March Medical 20 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Hospital Baltimore Yarbor If Under 1 Year If Under 24 Hrs. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Director 069-34-8114 1 ₹ M 2 □ F 69 New York Jan.15,1943 items 23a or 28a-f show ler must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD 1 ☐ Yes 2 XNo Anne Arundel Odenton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 513 King Malcolm Ave 21113 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Examiner Black, White, etc. or Completed by 1 ☐ Never Married 2X Married 1 X Yes 2 1963-7 If Yes, Give 1963-7 Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify "natural", White 3 Widowed 4 Divorced other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Management Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Franklyn Williams Margaret Broderick 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susan Williams / wife 513 King Malcolm Ave. Odenton, MD. 21113 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Important: If it any injury or o 1 Burial 2X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Metro Crematory Inc. 3/21/2012 Baltimore, Maryland Sprature of Funeral Service LicenseeStephanie Custer 22. Name and Address of Facility Cremation Society of MD.Inc. Frederick Rd. Baltimore, MD. 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician/ Acute disease or condition WERKS Medical resulting in death) Examiner than Sequentially list conditions, Examine years if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) the burial-trar Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Month Day Year Pregnant at time of death 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No 2 No 1 Yes Hospital or Attending Physician: Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be 2 No Hospital Other: 1 🗌 Yes မ 1 ✓ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred ✓ Natural 5 Pending To the Hospital or Attendir within 24 hours after death. To the Funeral Director: Af ☐ Accident 1 Yes 2 No Investigation the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated RISOO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3001 South Hanover 31. Date filed (Month, Day, Year) ** State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 17 0^{Month} Physician/ 2012 2:000 Michael Angelo Walker Medical 4a. Facility Name (if not institution, give street and number, 4c. County of Death 4b. City, Town, or Location of Death Examiner 5911 Queen Anne St. Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Social Security Number **Funeral** Min Hours 212-56-8691 1 **™**M 2 □ F Director Yrs 07/05/1951 Maryland 60 Usual Residence of Dec 10d. Inside City Limits 28a-f shov 10a, State 10c. City, Town or Location traumatic event, the Medical Examiner must be notified at Director 1x Yes 2 ☐ No MD N/A Baltimore 10f. Zip Code 10g. Citizen of What Country? ö 10e. Street and Numbe Funeral 23a 5911 Queenanne St. 21207 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) death 14. Race - American Indian, 12. Was Decedent Ever in U.S. Black, White, etc. ori 1 Never Married 2 Married þ Yes 2 No permit. Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☐ No Specify: Specify: Black "natural", 3 Widowed 4 Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) and Mental Hygiene. 12th Grade College (1-4 or 5+) Unemployed N/ABe 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 0 Willie Walker Mary Dorsey 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Nicole Gaskins (daughter) 5911 Queen Anne St., Balto., MD 21207 item 27 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place) 1 Removal from State Ξ 0 Department of Important: If any injury or once. 03/24/12 Baltimore, MD King Mem. Park 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Joseph Address of Brown Jr. Funeral Home 2140 N. Fulton Ave., Baltimore, I PA MD21217 Many 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death METASTATIC HEPATOCELLULAR CANCEL Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine and the burial-tran Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 as attending IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death use 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy been signed by the atter should be detached for u in the past 12 months?
1 ☐ Yes 2 ☐ No Month Vear Day 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has b lirector, page 2 sl autopsy perform 1 ☐ Yes 2 ☐ No Yes 2 X No 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 1 Yes 2 No 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA s after death.

I Director: After this cool in by the funeral directors မှ 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of 28d Describe how injury occurred 27 Manner of Death Certificate: iniury 1 Natural 5 Pending Accident Investigation 3 Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined City or Town, State) within 24 hours a **To the Funeral D**completely filled Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 3 29b. Signature and title of certifie 2 D16354

Registrar
DHMH 17 Rev 06-2011

State

900 CATON AVE BALTIMORE MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) EW COLE ST AGNES 900 CATC

31. Date filed (Month, Day, Year)

amend 18, per fh, g925 3-23-12 sm Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ 2012 MARCH 19 TESS K ZELIGMAN Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE 4 CANDLEMAKER COURT, BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday, **Funeral** 1 🗆 M 2 🗶 F Months Hours Min 01/24/1919 Director 064-12-8176 93 Usual Residence of Decedent Show ral", or items 23a or 28a-f shorexaminer must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit, Page 1 and 2 should be filed within 72 hours after death with the Maryland Funeral Director 1 Tes 2 X No BALTIMORE MD BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a USA 4 CANDLEMAKER COURT, #402 21208 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. or Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. "natural", 3 ₩ Widowed 4 □ Divorced Specify. WHITE Year or Dates th and Mental Hygiene.

27 is marked other than "natur traumatic event, the Medical I 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed, Elementary/Seconday (0-12) College (1-4 or 5+) HOMEMAKER OWN HOME Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 SADIE UNKNOWN SAMUEL KOPPELMAN Mondlin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health item 27 21136 MARILYN YOUSEM/DAUGHTER 338 LAUREN HILL COURT, REISTERSTOWN, MD or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State Department of H Important: If ite any injury or ot 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) HEBREW YOUNG MENS 03/20/2012 BALTIMORE, MD Signature of Funeral Sinvio Lifensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Ph.sician/ Medical resulting in death) **Examiner** Sequentially list conditions.
If any, leading to minimum at cause. Enter Underlying Cause (Disease or iinjury Examine Due to for esia don següence of attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical The law requires that the death certificate be Box 68760 IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) Live Birth 2 Fetal death in the past 12 month 1 Yes 2 No 9 Unknown detached for Month Day Year Pregnant at time of death P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has perform Yes 2 N 2 No 1 Tes To the Hospital or Attending Physician: eral Director: After this certific filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: ြင Other: 1 Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? Certificate: 28b. Time of 28d. Describe how injury occurred 1 X Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined within 24 hours a Medical 29a. Certifier 🌌 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature a D0071287 3-20-12 (Item 23a) (Type, Print) N. Chules St. # 4105, Baltimore, MD 2,204 6701 31. Date filed (Month, Day, Year) Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ MARCH 93 ELSIE G. ATWELL Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. Cify, Town, or Location of Death 4c. County of Death 11760 Augustine Herman Hwy. Kennedyville Kent Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day Jan . 17 **Funeral** 6. Sex 7. Age (In yrs. last birthday) 1 M 2X F 1929 83 **Director** 221-18-8691 Usual Residence of Decedent r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County death with the Maryland 10c. City, Town or Location Director MD Kent. Kennedyville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 11760 Augustine Herman Hwy. 21645 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 filed within 72 hours after al Hygiene. 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Page 1 and 2 should be file ment of Health and Mental I James Wilson Groves Helen Silcox 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 is G. Clifton Atwell (Husband) 11760 Augustine Herman Hwy. Kennedyville, MD 21645 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 D Other (Specify) Kennedyville Cemetery 3/19/12 Kennedyville, MD. Funeral Service 21. Signatur ²²Calena funeral Home of Stephen L. Schaech M00510 118 West Cross St. Galena, MD. 21635 sase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or wart failure. List only one cause on Immediate Cause (Final disease or condition resulting in death) Physician/ ei her Medical Due to (or +a a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of):

burial-transit attending physician the use as signed by the a d be detached fo ģ

Box 68760

P.O.

Records,

of Vital

Division

Physician/Medical

Completed by

Be

Certificate: To

Medical

29b. Signature and title of certifier

31. Date filed (Month, Day, Year) **NAR 2 3 2012**

Susan K. Ross, M.D.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

or Attending Physician: funeral hours after death.
uneral Director; After fulled in by the fun To the Hospital within 24 hours and To the Funeral I completed

State

23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Year Day Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? ☐ Yes 2 1 No 2 🗆 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 1100 Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 I ER/Outpatient 3 I DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation
Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

001703 C

516 Washington Ave. Chestertown, MD. 21620

3. Time of Death

9. Birthplace (State or Foreign

10d. Inside City Limits

1X Yes 2 ☐ No

Pennsylvania

White

Approximate Interval Between

Onset and Death

7 years

8:30 a M

2012

14. Race - American Indian. Black, White, etc.

29d. Date signed (Month, Day, Year)

Registrar

For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ ^MMar 19,^D2012 10:50 AM Virginia Arthur Helen Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Allegany Cumberland Country House Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 6. Sex **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 M 2 X Hours Oct 28, 1926 Country MD **Director** 215-20-7160 85 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Cumberland Allegany 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21502 15 Cumberland Street USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 🕍 No Specify: Completed 3 Widowed 4 Divorced white Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) MD State Unemploy. Office 12 claims examiner Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Lena Viola McCoy Franklin Leroy Scarlett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 713 Montgomery Ave. Cumberland MD 21502 Bill Arthur III son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🗡 Burial 2 🗆 Cremation 3 🗆 Removal from State Hillcrest Memorial Park 3/23/201 MD Cumberland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and carpellif Furilleral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ ALZHEIMER disease or condition resulting in death) YR3 Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine if any, leading to immediate Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?

1 Yes 2 No Pregnant at time of death Month Day 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by HYPER TENSION 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Vnknown OSTEOPOROSIS 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed Yes 2 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital 2 240 Other: စ္ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 SNatural 5 Pending work?
1 Yes 2 Accident
3 Suicide
4 Homicide 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 042054 30. Name and address of person who completed pauses (death (Item 23a) (Type, Print) nth, Day, Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		4	For	State	of Marylan					lental Hyg	giene	012	0011.1		
			State Registrar	Locati		Cer	tificate o	of Dea	th	2. Date of Dea	Reg. No.	UIG	0 7 1 9 1		
	ysicia: Medic		Decedent's Name (First, Middle, Katherine	Lasti	J.		Adk	ins			$9-\overset{\text{Day}}{2012}$	Year	3. Time of Death 8:35 P M		
	camine		4a. Facility Name (if not institution,	give street and nu	mber)		, ,		ation of Death		4c. Cou	inty of Death	,		
			Talbot Hospice		7 A (l	4 6 3-46 -1-1 1	If Under 1 Y	Easto	on Inder 24 Hrs.	O. Data of Dist		Talbo	olace (State or Foreign		
	neral ector	ľ	5. Social Security Number 016-12-3051	6. Sex 1 ☐ M 2 X F	7. Age (In yrs. In 102	as <i>t birthday)</i> Yrs.			ours Min.	8. Date of Birtl 02-24-	1910	9. Birth	Maine		
P	ы.	_	Usual Residence of Decedent 10a. State 10b. County		10c Cit	y, Town or Lo	eation					1	0d. Inside City Limits		
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with with	nust b	Funeral Director	1205 Washingto	n Drive				21663	3		U,	S.A.			
r deatl	iner n	Y Fu	11. Marital Status1 ☐ Never Married 2 ☐ Marr	Armed F	edent Ever in U.s orces? 2 X No	S. 13. \	Vas Decedent f Yes, specify (of Hispani Cuban, Me	ic Origin? (Spe exican, Puerto I	cify Yes or No- Rican, etc.)		Race - Americ Black, White,			
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2 hour	dical	plet	15. Deceder (Specify only highe	t's Education st grade completed	'	(Give	lent's Usual O	one during	most of worki	ng	16b. Kind o	of Business Inc	dustry		
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iled w	vent, t	Be	17. Father's Name (First, Middle, L	ast)		1		18.1	Mother's Name	(First, Middle,	Maiden Surn	ame)			
yland IId be filed Mental Hy	raumatic event, the Medical Examiner must be notified at	욘	Frank Jack	<u>_</u>						an Spa					
Mar 2 shou Ith and 27 is n	traum		19a. Informant's Name/Relationsh Ann K. Goodman		ep.					Route Number Easto n			Code)		
1 and 1 and 1 teal	other		20a. Method of Disposition		20b. F	Place of Dispo cemetery, crer	sition (Name o	of r place)		Date	20c. Locati	on - City or To	own, State		
Page ment c	ury or		1X Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S	gton, V	7a										
Baltimore, Marylari permit. Page 1 and 2 should be fi Department of Health and Mentai	any inj once.		21. Signature of Funeral Service L	e P.A. 21663	33										
			21. Signature of Funeral Service Licensee 21. Signature of Funeral Service Licensee 21. Signature of Funeral Service Licensee 22. Signature of Funeral Home P.A. P.O. Box 518 St. Michaels, Md 21663 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.												
Priysi	cian/	1	Immediate Cause (Final disease or condition	•	REPID	SCLEI	2000	. CA	MOUDE	SCULAR	_ Disc	FARE	Interval Between Onset and Death		
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Sertific Jentifica	ise as	n/M	IF FEMALE: 23b. Was decedent pregnant		utcome of pregna		7				23d	. Date of deliv	ery		
COTOS, F.O. BOX 08/00 Iaw requires that the death certificate be executed the season	should be detached for use as the burial-transit	Physician/Me	in the past 12 months? 1 Yes 2 No		e Birth 2 Fet gnant at time of		Other (speci					Month	Day Year		
at the C	etache		9 Unknown Part II. Other significant condition			sulting in the u	inderlying cau	se given in	Part I.	23e. Did to	bacco use o	contribute to the	he cause of death?		
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e taw requires	shou	Completed								24a. Was		4b. Were auto	psy findings available impletion of cause of		
The far	page	Com								perfo	rmed?	death? 1 ☐ Yes_			
VITAI ysician:	ector,	Be	25. Was case referred to medical examiner?	Hospital:			2	26. Place o	of Death (Check	only one)		Hos	nice Hse.		
OT VI ng Physi ter this c	ral din	는 일	1 Yes 2 No 27. Manner of Death	28a. Dat	Inpatient 2 e of injury	ER/Outpatie		injury at	☐ Nursing Ho	me 5 Resid	dence (X)	Other (Specif) curred	pice Hse.		
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DIVISION tal or Attendii rs after death.	in by th	Certificate:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	inca 28e. Plac	ce of Injury - At h		eet, factory, of	fice		28f. Location (S City or Tow		ımber or Rura	l Route Number,		
DIVISION OF VITAL RECO To the Hospital or Attending Physician: The law within 24 Hours after death. To the Eurosal Director Cattle	d filled	Medical (Physician: To the	best of my know	vledge, death	occured at the	time, date	e and place, an	d due to the ca	use(s) and m	anner as state	ed.		
the Ho hin 24	mplete	Mec	only one) 3 Certifying	Nurse Practions	asis of examination: To the best of m	ny knowledge,	death occurred	at the time	e, date and plac	e, and due to th	e cause(s) an	d manner as s			
o vit	2 00		29b. Signature and the of certified	V frith	1 by street			cense num				gned (Month, $3/5/$			
			30. Name and address of person					- /	1- 3			- 1 - /			
3 E	.\$		Robert J. Pat	terson,	M.D. 80	0S Tall	ot St.	St.	Mi chae	ls, Md.	2166	3			
Re	Stat egistra	te ar	31. Date filed (Month Pay Road)	5 2012 32	R gistrar's Signa	ature .	lade								
					r	- 4									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day 2012 9:00 P March 6. Physician/ Albert ABRAMSON Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Montgomery Bethesda 8801 Fernwood Road 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Social Security Number . Age (In vrs. last birthday **Funeral** Months Days Hours July 6 1917 New York 1 ¼ M 2 □ F 577-12-0136 94 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 28a-f shov 10a. State 10b. County "natural", or items 23a or 28a-f sho Director 1 Yes 2 X No Bethesda Maryland Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number Funeral United States 20817 8801 Fernwood Road 14. Race - American Indian death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. Black, White, etc. Armed Forces? 1 ☑ Yes 2 ☐ No þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 No Specify: If Yes, Give Completed 3 X Widowed 4 Divorced Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry ntal Hygiene. ed other than " event, the Me College (1-4 or 5+) Elementary/Seconday (0-12) Real Estate Developer Be 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event once. 17. Father's Name (First, Middle, Last) ပ္ Rose Reisberg Benjamin Abramson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5504 Edson Lane, Rockville, MD 20852 19a. Informant's Name/Relationship (Type, Print) Jeffrey Abramson, Son 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 X Burjar 2 Cremation 3 X Removal from State King David Memorial Gården 03/09/12 Falls Church, VA □ Other (Specify) 4 Donation Metropolitanifuneral Service, Inc. Sign rure of Fureral Service Licens 5517 Vine St., Alexandria, VA 22310 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Cardiac Arrhythmia disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Chronic Kidney Disease 2 Years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner 5 Years To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and Prostate Cancer that initiated events Due to (or as a consequence of) resulting in death) Last nding physician use as the burial Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy Live Birth 2 D Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ctopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 1 Yes 2 G Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 X No Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 ☐ Yes 2 🛣 No မှ 1 🗌 Inpatient 2 🗀 ER/Outpatient 3 🗀 DOA 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: injury 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Gertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one)

DHMH 17 Rev 7/2009

State Registrar 29b. Signature and title of certifie

31. Date filed (Month, Day, Year) **WAR 0 9 2012**

0. Name and address of person who completed cause of death (Item 23a) (Type, Print) Gilbert M. Eisner, M.D., 1120 - 19th St., NW, #200, Washington, DC

. Registrar's Signature

29c. License number

MD 2183

29d. Date signed (Month, Day, Year)

20036

March 7, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2012 Year March Physician/ Akinkuowo 5. 8:11 Stella Monolape рм , Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Montgomery Rockville 12912 Grenoble Drive If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral Months (Month, Day, Year) 577-78-4305 **Director** 1 M 2 X F 59 Yrs 2. Nigeria Usual Residence of Deced or 28a-f shov 10d. Inside City Limits 10a. State 10c. City. Town or Location must be notified at Director 1 Yes 2 XNo MD Rockville Montgomery 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 12912 Grenoble Drive 20853 USA death \ 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 14. Race - American Indian. the Medical Examiner Armed Forces?

1 Yes 2 No If Yes, specify Cuban, Mexican, Puerto Rican, etc. ö 1 Never Married 2 K Married þ 3altimore, Maryland 21215-0036 72 hours after Specify:Black 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates "natural", 3 Divorced 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Medical e 1 and 2 should be filed with of Health and Mental Hygien If item 27 is marked other th or other traumatic event, the Nursing Assistant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Esther O. Unknown Gabriel O. Fashipe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 is any injury or at Oluwole O. Akinkuowo/Son 8304 Ashford Boulevard, Laurel, MD 20707 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date March 16 cemetery, crematory or other place) 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Gate of Heaven Cemetery Silver Spring, MD 2012 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses Francis J. Collyins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ Cardiovascular Disease disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Hypertension Sequentially list conditions, if any, leading to immediate cause. Enter underlying Due to (or as a consequence of): Exami The law requires that the death certificate be executed Cause (Disease or injury that initiated events Atherosclerosis Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 attending physical for use as the b as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 Yes 2 No Day Year Month Pregnant at time of death ed by the a detached t 9 Unknown P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? ate has l page 2 s autopsy performed? Yes 2 No 1 Yes 2 No or Attending Physician: 25. Was case referred to medical director, 26. Place of Death (Check only one) Be Other: 4 \square Nursing Home 5 \blacksquare Residence 6 \square Other (Specify) 2 No 1 🗌 Yes ပ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1

✓ Natural 5 Pending work? 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: Air 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined To the Hospital Medical 🖾 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year)

State Registrar 31. Date filed (Month, Day, Year)

MAR 0 9 2012

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Bhailal Tejura, MD

D27572

1040 University Blvd. East, Silver Spring, MD 20903

March 7, 2012

Please Type or Print in Black Indelible ink. Ensure All Copies Are Legible.

	_		_	1 - ForzMEND#28aperIME, state Regis#MEND#28b+fiper	.3/16/11;BW,M DME;3/16/12;BM	iryland W,MbO	d / Depa o <i>Cer</i>	artmen rtificate	t of H e of D	lealth a Death	and M	lental Hy	giene Reg. No	.20	12	091	44
		Physicia Medic		Decedent's Name (First, Middle, I Mildred	Albertson							2. Date of De March 3,	ath		⁄ear	3. Time of Deat 11:57 A	th • M
		Examin		4a. Facility Name (if not institution, g Suburban Hospita				4b. City, Beth	Town, or e sda	Location o			4c	: County of	Death mer	У	
	,	Funeral Director		5. Social Security Number 227–14–7387 Usual Residence of Decedent	7. Age	90	st birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birl May 15	th y, Year)	921	9. Birthp Count 71rg	olace (State or For try) inia	eign
		Maryland :8a-f shov rtified at	rector	10a. State 10b. County MD Montgon		10c. City,	, Town or Lo kville	cation							1	0d. Inside City Lin	
		with the / s 23a or 2 ust be no	Funeral Director	10e. Street and Number 11911 Castlegate	e Court			10f. Zip	Code 0852				-	tizen of Wh		*	
	9800	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	11. Marital Status 1 ☐ Never Married 2 ☐ Marrier 3 ☒ Widowed 4 ☐ Divorced	12. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 ☒ N If Yes, Give Year or Dates.		l l	Was Deceder f Yes, speci	fy Cubar	i, Mexican	n, Puerto F	cify Yes or No- Rican, etc.)		14. Race - Black, V Specify:	America White e Vhit		
	21215-0036	vithin 72 hou liene. Ir than "nat the Medica	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	s Education grade completed) College (1-4 or 5+	+)	(Give I	dent's Usual kind of work O NOT use naker	done du		t of workin	ng		ind of Busin		lustry	
	yland 2	ld be filed v Mental Hyg larked othe atic event,	To Be	17. Father's Name (First, Middle, Las William E. Johns	•						other's Name (First, Middle, Maiden Surname) la Jane Milligan						
AIN	, Mar	nd 2 shou ealth and m 27 is m		19a. Informant's Name/Relationship Linda A. Tsantis			19h Mailin	Address Cast	(Street ar L eg a		ber or Rural Route Number, City or Town, State Zip Code) Court, Rockville, MD 20852					2 2	
57 N	Baltimore, Maryland	Page 1 a tment of H tant: If ite jury or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 4X Donation 5 ☐ Other (Spe		20b. Pla Georg Med	ace of Dispo getown ical (at Unit	ersi	⊉ty	March 2012	arch 4 20c. Location - City or Town, State Washington, D.C.					
1	Ball	permit Depar Impor any in		21. Signature of Funeral Service Lice	Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such									_		ices,P.A	•
131		Ph_sician/ Medical		23a. Part 1. Enter the disease, or co shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)		respiratory arr				Approximate Interval Between Sonset and Death Days							
100	Toggie	Examiner	er	Sequentially list conditions, if a y, leading to minimalists	b.					P	no	/					
3/3/		icate be executed I physician and Is the burial-transit	al Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a			/2	y fr								
	09/89	tificate be ng physic as the bi	Medical	IF FEMALE:	d	-							_				_
	. Box 6	Attending Physician: The law requires that the death certificate be executed as death. ector: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-trans.		23b. Was decedent pregnant in the past 12 months? 1 Yes No 9 Unknown	23c. If yes, outcome of 1 Live Birth 2 4 Pregnant at 1 9 Unknown	P. ☐ Fetal	death 3	Ectopic pr Other (spe						23d. Date o Month		ry Day Year	1
red	s, P.O	ires that to signed by Id be deta	by	Part II. Other significant conditions Coronary Arter		t not resul	Iting in the u	nderlying ca	ause give	en in Part I	I.					e cause of death?	
Wildred	Records,	has beer ye 2 shou	Completed	Severe Obstruc		ary 1	Diseas	se				24a. Was a	SV	prio	r to con	sy findings availal npletion of cause	ole of
2	al Re	sician: The la certificate ha rector, page ;		25. Was case referred to medical									rmed? 2 X No	o 1 E		2 🗌 No	
5	f Vital	Physici this cer al direc	၉	examiner? 1 X Yes 2 No 27. Manner of Death	Hospital:				Other	4 🗌 Nu	ırsing Hon	ne 5 🗌 Resid			Specify)		
.50	on of	ending l sath. rr: After he funer	Certificate:	1 ☐ Natural 5 ☐ Pending 2 🔀 Accident Investigat	1 ☐ Natural 5 ☐ Pending O3 (Nonth, Pay Year) injury work? 2 ☑ Accident Investigation 1 ☐ Yes 2 ☐									Fall			
Albertson	Division	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director.		3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determine		y - At hom (Specify) Home	ne, farm, stre	eet, factory,	office		2 1	8f. Location (S 119 th 11 Tow ROCKV 11	treet and n, State as t 1	d Number o	r Rural I	Route Number, urt	
4		e Hospi 24 hou e Funer aletely fil	Medical	(Check 2 \(\subseteq \text{ Medical Exa} \)	hysician: To the best of m nminer: On the basis of exa lurse Practitioner: To the l	amination a	and/or invest	igation, in m	y opinion	i, death oc	place, and	d due to the ca	use(s) ai	nd manner a	as state	d. se(s) and manner s	stated.
1		within Mithia		29b. Signature and title of certifier	Vasgre	2000 01 111)	, martineage,	29c.	License	number	is and place		29d. Dat	te signed (N	1onth, D	lay, Year)	
				30. Name and address of person who Natalie Vasc		ath (Item 2	23a) (Type, P	rint)	8600 Beth	Old esda	Geor , MD	getown 20814	Roa	ad			
		Stat Registra	<u> </u>	31. Date filed (Month, Day, Year) NAR 0 9 20	32. Registrar's	s Signatu	far.	W.									

12-01874 Lou Ruth Blake Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

ou Ruth Blake		tment of Health and Mental Hy ficate of Death	giene Reg. No. 2012 09145
Physician/ Medical Examine	Decedent's Name (First, Middle,Last) Decedent's Name (First, Middle,Last)	2. Date of Death Month Day Year March 1, 2012 3. Time of Death 1030 hrs	
	4a. Facility Name (if not institution, give street and number) Calvert Memorial Hospital	4b. City, Town, or Location of Death Prince Frederick	4c. County of Death Calvert
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last 213-44-4625 1 _{1 M 2} F 81	t birthday) If Under 1 Year If Under 24Hrs. Months Days Hours Min.	8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign Country) MD
with the Maryland 1s 23a or 28a-f ahow any te notified at once.	MD Calvert I 10e. Street and Number 12110 Rousby Hall Road	own or Location Lusby 10f. Zip Code 20657 13. Was Decedent of Hispanic Origin? (Sp.	
15-0036 filed within 72 hours after death with the Maryland I Hygiene. 4 other than "natural", or items 23a or 28a-f she 5, the Medical Examiner must be notified at once 6 Completed by Funeral Director	4 Divorced in res, give real or Dates:	If Yes, specify Cuban, Mexican, Puerto I 1 Yes 2 No specify: 6a. Decedent's Usual Occupation (Give kind of weduring most of working life. DO NOT use retirements to the memaker.	Specify: Black ork done 16b. Kind of Business/Industry
	William Henry Buck	18.Mother's Name	(First, Middle, Maiden Surname) Johnson
e, MD 2121 and 2 should be fi realth and Mental i item 27 is marked To Be	Philis A. Hurley/daughter 20a. Method of Disposition 20b. Pla	11911 Surfbird Ci	ural Route Number, City or Town, State, Zip Code) 32256 rcle Jacksonville, FL Date 20c. Location - City or Town, State
Baltimore, MD 2 permit. Pages and 2 shoul Department of Health and In Important: If item 27 is u injury or other traumatic	1 Nation 2 Cremation 3 Removal from State E as State 21. Signature of Funeral Service Licensee	22. Name and Address of Facility Sew	4/2012 Lusby, MD rell Funeral Home, P.A. Rd. Prince Fred.,MD2067
Physician /Medical _ixaminer	or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, b.	oo not enter the mode of dying, such as cardiac or nfection complicating Cardiovascular Diseas	Hypertensive Between Onset and
be executivities and unial - tra	▼ UNPENDED AMENDED 23a, 27, pe	2 Fetal death 3 Ectopic pregnar	23d. Date of delivery ncy Month Day Year
, P.O. Box 6876 res that the death certificate signed by the attending phy be detached for use as the I d by Physician/M	1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resu	J Other (Specify)	23e. Did tobacco use contribute to the cause of death?
Records The law requirate has been page 2 should			1 Yes 2 No 3 Probably 4 V Unknown 24a. Was an autopsy performed? 1 Yes 2 No 1 Probably 4 V Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No 1 Yes 2 No
ision of Vital I Attendin Physician; or death. retor: A ter this certifi by the fureral director, cation: To Be C	1 Yes 2 No 1 Inpatient 2 El		g Home 5 Residence 6 Other Scene 28d. Describe how injury occurred
Division o To the Hospital or Attending within 24 hours af or death. To the Funeral Director: Alte completely filled in by the fune ledical Certification:			28f. Location (Street and Number or Rural Route Number, City or Town, State) due to the cause(s) and manner as stated.
To the Hot within 24 h To the Fur completely	ane B	29c. License number O.C.M.E.	t the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) March 6, 2012
State		00 W. Baltimore Street, Baltimore, MD	21223
Registra	31. Data filed Manth Day Year 32 Registrate Signature A. S. San		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

nessa Blake		State of Maryland / Department of Certificate of Ce			al Hygiene		201	2 09 141					
Physici	an/	Registrar 1. Decedent's Name (First, Middle,Last)			2. Date o			3. Time of Death					
edical Exami		Venessa Marie Blake				5, 20	ay Year 12	1545 hrs					
		Facility Name (if not institution, give street and number) Calvert Memorial Hospital		wn, or Location of Frederick	Death		4c. County of Dea	eth .					
Funeral		Social Security Number 6. Sex 7. Age (In yrs. last birthday)		<u> </u>	24Hrs. 8. Date	of Birth(sirthplace (State or					
Director		217-68-6478 1 M 2KF 56 Y	Months	Days Hours	Min. 09/	07/	1955 Fore	eign Country) MD					
		Usual Residence of Decedent											
bw any		MD Calvert Lus						10d. Inside City Limits 1 Yes 2 No					
ryland a-f sh	ctor	MD Calvert Lus	10f. Zip C	Code		10a.	Citizen of What Co	71					
r death with the Maryland or items 23a or 28a-f show any must be notified at once.	Director	8559 Nursery Road		0657		_	USA	•					
with t ms 23a be not				t of Hispanic Origi Cuban, Mexican,			14. Race - Ame White, etc.	erican Indian, Black,					
	Funeral	1 Yes 2 No			ruerto Ricari, etc)		- 1-					
2 hours afte "natural", Examiner	by	or Dates:		No specify: ccupation (Give k	ind of work done	16	Specify: B1 a						
72 hou a "nat	etec	Elementary/Secondary (0-12) College (1-4 or 5+)		ng life. DO NOT u	ise retired)		United (Cerebral					
0036 within iene. er tha	Completed		Coac				Palsv						
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be flied within 72 hours after death with the Maryland bopartment of Helant and Mental Hygiene. Important: If item 77 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once	Be Co	17. Father's Name (First, Middle, Last) Leroy Francis Blake, Sr.		18.Mother's	Name (First, Mic Ruth	idle, Mai Bu							
212 ould bould bould bould bould bound bou	To E						er, City or Town, Sta						
MD and 2 show alth and m 27 is aumatic					ne Fay		eville,	NC 28314					
Baltimore, permit. Pages I an Department of Hea important: If iter		20a. Method of Disposition 1 Name Burial 2 Cremation 3 Removal from State Crematory or Control D	other place)	· I		ı	•						
ltim it. Pag rtment ortant:		4 Donation 5 Other Specify.						Fred.,MD					
Bal perm Depa Impo injur		Deal of Swell 1	451 D	ares Bo	Rewed!	Þr	neral Ho ince Fre	me, PDA0678					
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter failure. List only one cause on each line.	r the mode of	dying, such as ca	rdiac or respirato	ry arrest,	, shock, or heart	Approximate Interval Between Onset and					
Medical Examiner		Immediate Cause (Final disease a. <u>Influenza and MRSA</u>]	Pneumo	nia				Death					
m'		b											
	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause											
+	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):											
tO, e be executed ysician and burial - transit	鱼匠	d.	~026 /	0 12 0				-					
6 be ex ysician burial	edical	▼ UNPENDED	,g920 4	1-9-12 SI	li	_	00 4 Data of della						
Box 6876(he death certificate the attending phy hed for use as the b	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 F	Fetal death	3 Ectopic	pregnancy		23d. Date of delive Month	Day Year					
OX 6	sici	Pregnant at time of death	Other (Specif	y)									
D. B. It the de ached t		Part II. Other significant conditions contributing to death but not resulting in the	a underlying c	ause given in Par	t I. 23e.	Did toba	cco use contribute t	o the cause of death?					
cords, P.O. law requires that the has been signed by 2 should be detach	d by				1	Yes	2 No 3 Pr	obably 4 🗹 Unknown					
rds v requi s been should	olete					Was an autopsy		autopsy findings available completion of cause of					
Reco	Completed					performe Yes 2							
Division of Vital Records, and retained Physician: The law required and a forest	Bec	25. Was case referred to medical examiner? Hospital: 1 Input iont 2 ER/Outpatien		Place of Death (
Physicar this eral dir	은	1 V Yes 2 No Pospital 1 Inpatient 2 ER/Outpatiel 27. Manner of Death 28a Date of Injury 28b. Time of		c. Injury at Work?	Nursing Home 5		sidence 6 Oth	er:					
on of \ ending Phy ath. r: After the	tion	1 X Natural 5 Pending (Month, Day, Year) 1 Yes 2 No											
Division pital or Attent cours after death neral Director: filled in by the	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural or Town, State)											
Dji spital cours at seral I	Cert	4 Homicide determined (Specify)			1 0110	WII, State	=)						
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after deer: After this certificate has been signed by the attending physician and completely filled in by the tuneral director, page 2 should be detached for use as the burial - transi		29a Certifier 1 Certifying Physician: To the best of my knowledge, death occ (Check only one) Medical Examiner: On the basis of examination and/or investig											
To To Com	Medical	and manner stated 29b. Signature and title of certifier	29c.	License number	···	2	9d. Date signed (M	onth, Day, Year)					
		anet		O.C.M.E.		١	March 6, 2012						
6		30. Name and address of person who completed cause of death (Item 23a)											
Ψ		Ana Rubio MD. Assistant Medical Examiner 900 W. Ba	Itimore Sti	reet, Baltimor	e, MD 21223		F-						
S	tate	31 Date filed (Month, Day, Year) 32. Registrar's Signature	/										

OCME

	1	Pleas For State Registrar	State of		d / Dep		nt of H	lealth a				9	ible.	001	1. 7
Physician Medica	/	1. Decedent's Name <i>(First, Midd</i> le, Melvin	Lee BARNE							2. Date of D Month	eath Di	av	Year 2012	3. Time of De	eath A M
Examine	r ⁴	4a. Facility Name (if not institution, of Meritus Medica)		r)				Location o			40	Was!	of Death hingt	on	
Funeral Director	1	5. Social Security Number 723-14-7746 Usual Residence of Decedent	5. Sex 7.	Age (In yrs. la	33 Yrs.	If Unde Months	Pr 1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of B (Month, E May 15	irth Day, Year) 19	28	9. Birthp Coun Mary	lace (State or Fi try) Land	oreign
Maryland 28a-f show otified at		10a. State 10b. County Maryland Washin	ngton		y, Town or Lo							,	1	0d. Inside City I	
with the s 23a or ust be n	runeral D	10e. Street and Number 15431 National	Pike			10f. Zi	p Code 21	740				itizen of V	What Coun \mathbf{A}_ullet	try?	
ter d	2	11. Marital Status 1 Never Married 2 Marrie 3 Widowed 4 Divorced	12. Was Decede Armed Force 1 Ves 2 If Yes, Give Year or Dates	s? □ No 194	-6-		cify Cubar	n, Mexican	i, Puerto	ecify Yes or No Rican, etc.))-		e - Americ k, White, e whi	etc.	
vithin 72 hou iene. r than "natu	Completed	15. Decedent (Specify only highes Elementary/Secondary (0-12)		or 5+)	(Give life. E	dent's Usu kind of wo OO NOT us anica	ork done d e retired)	uring most		king	16b. I		e co.	•	
ld be filed w Mental Hyg arked othe atic event,	10 Be										Surname Mau	4		A	
id 2 shou ealth and n 27 is m er traum	İ	19a. Informant's Name/Relationshi Melvin L. Barne		on						al Route Numb ve, Hen				la 89074	' +
Page 1 arment of He ant: If iten ury or oth		20a. Method of Disposition 1 Burial 2 ☐ Cremation : 4 ☐ Donation 5 ☐ Other (Sp		ato C	Place of Dispo emetery, cre enlawr	matory or	other place	e) Ark	larch	Date 1 1312			City or To	wn, State , Maryl	and
permit. Departimont Import any inj once.		21. Signature of Faneral Service Lie	Renk.	•		2. Name a 15 Ea			LIT	innich /d., Ha				yland 2	21740
Physician/ Medical Examiner	Examiner	23a. Part 1. Enter the disease, or of shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	a	as a consequal as a consequal	UN (uence of): •	ter the mod	13	g, such as		or respiratory a	arrest,			Approximate Interval Betwee Onset and Dea	
be ey	Medical	that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	c. Due to (or d. 23c. If yes, outco 1	th 2 🗀 Feta nt at time of o	incy	Ectopic Other (s		у				23d. Dat	te of delive	ery Day Yea	r
s tha gned be d	Completed by Pny	Part II. Other significant condition	ns contributing to dear		_		cause give	en in Part	1.	1 [24a. Wa	Yes 2	! □ No	3 Prot	ne cause of deat	known
an: The la tificate ha tor, page		25. Was case referred to medical					26. Pla	ace of Dea	th (Chec	1 Yes	opsy formed? 2 X N	lo 1	death?	mpletion of caus	Se ()
Physicia this cert aral direct	۹	examiner? 1 Yes 2 No 27. Manner of Death	Hospital: 1 Ing	patient 2	ER/Outpatie		Othe	er: 4 🗆 Nu		ome 5 Res)	
r Attending er death. rector: Afte by the func	Certificate:	Natural 5 Pending Accident Investig: Suicide 6 Could n Homicide determin	(Month, ation ot be 28e. Place of	Day, Year)	injury ome, farm, st	М		? Yes 2□] No		(Street a	nd Numbe		Route Number,	
Hospital or 4 hours aft Funeral Di tely filled in	Medical	29a. Certifier 1 Certifying (Check 2 Medical Ex	Physician: To the best	t of my know	 ledge, death	occurred a	at the time	, date and	l place, a	and due to the	cause(s)	and mann	ner as state	ed. use(s) and manne	er stated.
To the within 2 To the comple		only one) 3 L Certifying 1	Nurse Practitioner: To	the best of r	ny knowledge	e, death oc	c. License	number	te and pl	lace, and due to	29d. Da	ate signed	Month, L	Day, Year)	
N-10+1		30. Name and address of person w	ho completed cause of	of death (Item	23a) (Type,	Print)	Lera	Aue	40	33	Nn 1	NO	217	42	
State Registra		31. Date filed (Month Day Year)		istrar's Signa	ture	della	1								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2<u>012</u> рм March 8:00 Medical Harrison Louis BAKER 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Williamsport Washington Homewood Health Care Center If Unde Year If Under 24 Hrs. g. Birthplace (State or Foreign . Age (In yrs. last birthdav 8. Date of Birth **Funeral** Social Security Number (Month, Day Month Hours Min 1 🏻 M 2 🗆 F Illinois Yrs. Director 1918 383-10-2003 93 Nov Usual Residence of Decedent show 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State death with the Maryland must be notified at Funeral Director 1 Tes 2 X No 28a-f Washington Williamsport Maryland| 0 10f. Zip Code 10g. Citizen of What Country? 23a 21795 USA 16505 Virginia Avenue ral", or items? 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. Completed by 1 Never Married 2 Married permit. Page 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examir Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify Specify: 3 X Widowed 4 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) U.S. Government Electrical Engineer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Zita Lapra Harrison Baker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 128 Longcroft Road, Winchester, Va. 22602 Paul H. Baker - Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of Important: If it any injury or o once. 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Hagerstown Crematory 3/10/2012 Hagerstown, Maryland 21. Signature of Funeral Service Lice 22. Name and Address of Facility Minnich Funeral Home 415 E. Wilson Blvd. Hagerstown, Maryland 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between set and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or linjury and burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): nding physician Physician/Medical the as use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No for Month Day Year Pregnant at time of death signed by the at d be detached fo þ Completed page 2 s certificate Be Medical Certificate: To

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 24 hours after death.
Funeral Director: After eted filled in by the funeral within 24 hou

To the Fune

completed fi

9 Unknown	9 L Unknown		
Part II. Other significant conditions of	contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown	
		24a. Was an autopsy performed? 1 \(\sumeq \text{Yes} = 2 \) \(\sumeq \text{No} \) 24b. Were autopsy findings available prior to completion of cause of death? 1 \(\sumeq \text{Yes} = 2 \) \(\sumeq \text{No} \) 1 \(\sumeq \text{Yes} = 2 \) \(\sumeq \text{No} \)	
5. Was case referred to medical	Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1		
examiner? 1 Yes 2 No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing H	ome 5 Residence 6 Other (Specify)	
2 Accident Investigation	(Month, Ďay, Year) injury work? n M 1 ☐ Yes 2 ☐ No	28d. Describe how injury occurred	
	28e. Place of Injury - At home, farm, street, factory, office		
(Check 2 Medical Exam	iner: On the basis of examination and/or investigation, in my opinion, death occurred a	at the time, date and place, and due to the cause(s) and manner stated.	

h, Day, Year)

29d. Date signed

184

State Registrar

		ertificate of Death Reg. No. 20 2 0 9 4	9
Physician	MADCADED E DEEDOMEEN	2. Date of Death Month Day Year MAPON OF 2012	и.
/Medica Examine		MARCH 06 2012 3:02 P 4b. City, Town, or Location of Death 4c. County of Death	_
}	ENVOI OF DENION HEALTHCARE CENTER	DENTON CAROLINE	
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	Months Days Hours Min. (Month, Day, Year) Country)	'n
Director	215-36-2411 TIME 2X F 72 Yrs. Usual Residence of Decedent	APRIL 19, 1939 MARYLAND	_
yland Iow	10a. State 10b. County 10c. City, Town or	Location 10d. Inside City Limit	s
a-f sh	MARYLAND TALBOT EASTON	1 👿 Yes 2 🗆 N	0
vith the Ma	10e. Street and Number	10f. Zip Code 10g. Citizen of What Country?	_
ified within 72 hours after death with the Maryland Hygiene. Whysiene. Whysica "natural", or items 23a or 28a-f show ant, the Medical Examiner must be notified at a completed by European Disorbe.		21601 USA	
fter death v r ftems 23a liner must	11. Marital Status 12. Was Decedent Ever in U.S. 13. Armed Forces? 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ▼ No	B. Was Decedent of Hispanic Origin? (Specify Yes or No- lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc.	
urs aff		1 ☐ Yes 2 【XNo Specify: Specify: WHITE	
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be fill tall H and out out of the control out of the control out		18. Mother's Name (First, Middle, Maiden Surname)	
should ind Men warke umatic		MARY EMBERT	
d d 2	TO GETTING	iling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)	
permit. Pages 1 and 1 bepartment of Health Important: If Item 27 any Injury or other tr	20a. Method of Disposition 20b. Place of Dis	502 REED CIRCLE RIDGELY, MARYLAND 21660 position (Name of Date 20c. Location - City or Town, State	
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permit. Departm Importa any Inju		03/00/2012 MIDION, IID	
Depa Impo any li	JOHN R. MERCERON	ELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 200 S. HARRISON ST. EASTON, MD 21601	
ifficate be executed g physician and as the burial-fransit earthe burial-fransit edited Examiner	rany, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): C. Due to (or as a consequence of):	CULAR ACLIDENT WIEEKS POTIC CARDIOVASCULAR DUSASE YEARS	
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	HTPERTENSION	24a. Was an autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 1 □ Yes 2 □ No	е
iclan: certific ector,	25. Was case referred to medical examiner?	26. Place of Death (Check only one)	_
Phys rithis ral dir	1 Inpatient 2 ER/Outpati	— Content of the state of the s	_
ending sath. or: After he funer	1 Natural 5 ☐ Pending (Month, Day Year) 2 ☐ Accident investigation		
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director, Medical Certification: To Be C		City or Town, State)	
the Hospl in 24 hou the Funer pletely fil	one) Creek only 2 Medical Examiner: On the basis of examination and/or and manner stated.	ath occurred at the time, date and place, and due to the cause(s) and manner as stated. investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)	
To t To t	29b. Signature and title of certifier	29c. License number 29d. Date signed (Month, Day, Year)	
•	The many ATTENDING OUT		
	Name and address of person who completed cause of death (Item 23a) (Type TAUM, R., NBOLDMD 32)	BLOOMING PULL FED GRASBURG M	1
State	31. Date filed (Month, Day, Year) 32. Registrar's Signature	1 - 1 - 1 - 1 - 1 - 1	-

State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Registrar

21215-0036

Box 68760

P.O.

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death BRAZELL PM Month Physician/ FRANCIS 2012 Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Examiner Annapolitan Assisted Living Annapolis Anne Arundel 5. Social Security Number If Under 1 Year If Under 24 Hrs. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** (Month, Day, Year) Months Hours Min. Days 1 M 2 D F Director 123-28-1536 76 09/10/1935 New York Usual Residence of Decede show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location aţ the Maryland Director ms 23a or 28a-f s must be notified MD 1 Yes 2 X No Calvert Dunkirk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3440 Lancer Court 20754 U.S.A items permit. Page 1 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 12. Was Decedent Ever in U.S. Examiner was becedent Ever in 0.5. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates.1955—57 9 þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: white "natural", Completed Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 18b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) the cable Splicer telephone company other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Anna Lanty William F. Braze11 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt of Health a t: If item 27 i or other tra Margaret M. Webb, daughter 3440 Lancer Court, Dunkirk, MD 20754 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any injury or once. 03/10/2012 Clinton, MD 4 ☐ Donation 5 ☐ Other (Specify) Resurection Cemetery 21. Signatury of Funeral Service License 22. Name and Address of Facility Rausch Funeral Home. 8325 Mt. Harmony Lane, Owings, MD Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. terval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying the attending physician and the for use as the burial-transit Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Completed by Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day Pregnant at time of death naffer death.

I Director. After this certificate has been signed by the a 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed death? 2 No 1 Yes 1 Yes 2 No Be (25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred iniury 1 Natural 5 Pending 1 Yes 2 No 2 Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide filled in by determined City or Town, State) within 24 hours af **To the Funeral D**completely filled i Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Vertifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29c. bicense numbe 29d. Date signed (Month, Day, Year) 18

107 State

DHMH 17 Rev 06-2011

Registrar

NSE

30. Name and address of person wto completed cause of death (Item 23a) (Type, Print)

UE

31. Date filed (Month, Day

AY LOR

32. Registra 8

ANNAPOLIS, M.D. 21401

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of M	aryland		aπmer <i>rtificat</i>			na IVI	ental Hy	giene Reg. No.	012	09152
Phys	sicia	n/	1. Decedent's Name (First, Middle, La	,							2. Date of De Month	Day	Year	3. Time of Death
	edic ımine		4a. Facility Name (if not institution, give	CHRISTENSE e street and number)	ΞŊ		4b. City,	Town, or l	Location of [Death	02	4c. Cou	2012 nty of Death	
			UN(UERSITY OF MARY) 5. Social Security Number 6. 8					LTIMO	DRE If Under 24	1 Hre	O. Data of Di	+1-	T a Bisth	wless (Chate - Fersian
Fune Direc			217-26-1308	1 □ M 2 🔀 F		st birthday) Yrs.	Months			Min.	8. Date of Bir (Month, Da 6/6/19	ay, Year)	Coul	place (State or Foreign ntry) y land
and show	ă	ö	Usual Residence of Decedent 10a. State 10b. County		80 10c. City	, Town or Lo					0, 0, 2			10d. Inside City Limits
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with the	nst be t	Funeral Director	10e. Street and Number 130 Hearne Road	i			10f. Zip	Code	21401			10g. Citizen		intry?
DESIGNATION CE, INTERLY ISING Z 1.Z 1.3-UUSO permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important if item 27 is marked other than "natural", or items 28a or 28a-f show	i Examiner m	کر اکر	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 Yes 2 If Yes, Give Year or Dates.			Was Dece f Yes, spe 1 Yes	cify Cuban	ı, Mexican, F	n? (Spec Puerto F	eify Yes or No- Rican, etc.)		ace - Ameri lack, White, lfy:	
thin 72 hou	ne medica	Completed	15. Decedent's l (Specify only highest g	Education rade completed) College (1-4 or 5	i+)	life. D		rk done du	tion <i>uring m</i> ost o	f workin	ng	16b. Kind o		ndustry
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Mary 2 should th and N 7 is ma	ranma		19a. Informant's Name/Relationship (_					er, City or Town		21220
fe, I 1 and 2 f Health item 2:	otner	ŀ	Gerald Christens 20a. Method of Disposition		20b. PI	ace of Dispo	sition (Na	ne of			<u>ad, Ca</u> ate	20c. Location		
baltimo	njury or		1 ☐ Burial 2 🔀 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Spec	ify)	Ba	metery, crer ltimor	e Cr	emato	ry 3					Maryland
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Ph _a sici			23a. Part 1. Enter the disease, or conshock, or heart failure. List only Immediate Cause (Final disease or condition). . 1 - 0 1988	. Do not ent		e of dying	, such as ca	ardiac o	respiratory A	rrest,		Approximate Interval Between Onset and Death
Medi Exami	ner	_	resulting in death) Sequentially list conditions,	Due to (or as a	a consequ	ence of):		14		3/	1 m			11 days
ted J		Examiner	if any, leading to immediate Find and riving Cause (Disease or injury	Due to (or as	a consequ	ence of):			Don	R	NO.	3/.		
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DOX OO death certifie the attending		Σ	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome 1 Live Birth 4 Pregnant a 9 Unknown	2 Fetal	death 3	☐ Ectopic ☐ Other <i>(sp</i>		,				Date of deliv	very Day Year
uires that the signed by an aligned by		≥	Part II. Other significant conditions	contributing to death b	ut not resu	ılting in the u	ınderlying	cause give	en in Part I.					the cause of death?
The law requires ate has been signance 2 should be	280	Completed									24a. Was auto perfe 1 \sum Yes			opsy findings available ompletion of cause of
VICAL ysician: s certific	100	Be	25. Was case referred to medical examiner? 1 ☑ Yes 2 ☐ No	Hospital:				Othor	ce of Death					
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LIVISION tal or Attendir s after death. al Director: Af			4 ☐ Homicide determined	building, etc			eet, lactor	, onice		- 1	City or Ton	wn, State)	Annapol	
n 24 hour e Funera	letely III	Medical	(Check 2 L Medical Exam	vsician: To the best of niner: On the basis of exee Practitioner: To the	xamination	and/or inves	tigation, in	my opinior	n, death occu	lace, an	d due to the c the time, date	ause(s) and m and place, and	due to the ca	ause(s) and manner stated.
			29b. Signature and title of certifier			3		. License	number	,		29d. Date sig	ned (Month,	
£0 5			30. Name and address of person who	completed cause of d	eath (Item	23a) (Type, F	Print)	1013	88			02 29	2012	
			Khanjan Nagarsheth	22 S. Green			none i	no.	21201					
	State istra	e r	31. Date filed (Month, Day, Year)	012 32. Registra	ar's Signati	ne .			_					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1 Decedent's Name (First Middle Last) 2 Date of Death 3. Time of Death Day 2012 Month Physician/ March James Edward Canter, Sr 7:47A Medical 4a. Facility Name (if not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death Examiner Charles La Plata Genesis Rehabilitation Center Social Security Number If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex 1 ♣ M 2 ☐ F Funeral Days Hours 06/29/1929 Hughesville, MI Director 217-26-4310 Usual Residence of Decedent 28a-f show 10c. City, Town or Location 10d, Inside City Limits 10a. State 10b. County 72 hours after death with the Maryland Examiner must be notified at Director 1 Tes 2 No Hughesville Charles 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a or Funeral 20637 15345 Sunset Drive USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?1 X Yes 2 □ No 14. Race - American Indian, Black, White, etc. "natural", or 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 K No Specify Specify: White 3 Widowed 4 Divorced Completed Year or Dates 1 and 2 should be filed within 72 hours of Health and Mental Hygiene. item 27 is marked other than "natur other traumatic event, the Medical I 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12th Mason Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Frank Wood Canter Marguerite Cecilia Burch 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Teresa Burch / Daughter 14805 Oaks Road, Charlotte Hall, Maryland 20622 20b. Place of Disposition (Name of cemetery, crematory or other place)
St. Mary's Catholic Church Cemetery 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 03/16/2012 4 Donation 5 Other (Specify) Bryantown, Maryland 22. Name and Address of Facility Brinsfield-Echols F.H., P.A. 21. Signatury of Fune / Lervice Licenses #M00817 30195 Three Notch Rd., Charlotte Hall 23a. Part 1. Ento the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final hvsician/ OFONCUY disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-transit Cause (Disease or iinjury that initiated events Due to for as a consequence of): 1-ensil resulting in death) Last Physician/Medical Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Year Month Day Pregnant at time of death Unknown 9 Unknown P.O. | certificate has been signed by rector, page 2 should be detacl Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Nonknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed?

1 Yes 2 No death? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 2 No 1 Tes 4 Nursing Home 5 Residence 6 Other (Specify) ည 1 Inpatient 2 ER/Outpatient 3 IDOA After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No Natural 5 Pending within 24 hours after death.

To the Funeral Director: Af
completed filled in by the fu 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Waltorf TOPTIVA

State Registrar Titt any Game

31. Date filed (Month, Day, Year,

4140 Old Washing

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 03 2012 80 9:42 а м James Guy Caponiti Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 31 Greenhouse Pl. Calvert Huntingtown 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** 1 🏝 M 2 🗆 F Days Hours 07/21/1922 577-28-9530 Director 89 Usual Residence of Decedent "natural", or items 23a or 28a-f show idical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No MD Calvert Huntingtown 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 31 Greenhouse Pl 20639 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. by 1 Never Married 2 Married 1 ☐ Yes 2 🗓 No 72 hours after If Yes, Give Year or Dates 1 Yes 2 X No Specify: Specify: Completed 3 X Widowed 4 Divorced White permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical once. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 12 College (1-4 or 5+) Barber Self-employed Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Carmella (unk) Joseph Caponiti 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Naomi Catania / Daughter 31 Greenhouse Pl., Huntingtown, MD 20639 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🗷 Burial 2 🗆 Cremation 3 🗆 Removal from State Washington National 03/12/2012 4 ☐ Donation 5 ☐ Other (Specify) Suitland, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Lee Funeral Home Calvert, P.A. Gary J. Goff 8200 Jennifer Lane, Owings, MD 20736 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ cel disease or condition resulting in death) Medical s a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Exami attending physician and for use as the burial-transit Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Pregnant at time of death 9 Unknown 9 Unknown as been signed by 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🗹 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of certificate has autopsy performed? Yes 2 No page death? 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital 2 No 1 Yes 4 ☐ Nursing Home 5 🔀 Residence 6 ☐ Other (Specify, ျပ 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Hospital or Attending Pl 124 hours after death.
 Funeral Director: After the Certificate: 28c. Injury at 28d. Describe how injury occurred Natural
Accident
Suicide injury 5 Pending work? 2 🗌 No Investigation the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide completed filled in by determined City or Town, State) 24 hours 1

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation in my parising death account. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier of person who completed cause of item 23a) (Type, Print) 30. Name and addres den 5

Registrar

Saymon

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

Merrimac

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Registrats

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State of Maryland / Department of Health and Mental Hygiene State of Maryland / Department of Health and Mental Hygiene State of Maryland / Department of Health and Mental Hygiene State of Mental Hygiene State 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Medical 4b. City, Town, or Location of Death County of Death 4a. Facility Name (if not institution, give street and number) Examiner GAITHERSBURG MONTGOMOR GIRARA If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In vrs. last birthdav 8. Date of Birth g. Birthplace State or Foreign **Funeral** 1 □ M 2 1 F Months Hours Min. oct. 22, 1944 Hong Kong 220-57-5699 Director 67 Usual Residence of Decedent 28a-f shov 10a, State 10b. County 10c. City, Town or Location 10d, Inside City Limits with the Maryland event, the Medical Examiner must be notified at Director 1 Yes 2X No MD Gaithersburg Montgomery 10e. Street and Number 10f. Zip Code 23a or 10g. Citizen of What Country? Funeral 20877 430 Girard Street #201 Hong Kong or items permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, White, etc. 11 Marital Status Armed Forces? Yes, specify Cuban, Mexican, Puerto Rican, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Asian If Yes, Give Year or Dates 3 X Widowed 4 □ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Nurse Assistant Medical Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Jade-Lam Lam Siew-Seng Chun 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tai-Hoi Shiu (Son) 10910 Silent Wood Place, Gaithersburg, MD 20878 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Metropolitan Crematory 1 Burial 2 X Cremation 3 Removal from State injury or ch 10, 4 ☐ Donation 5 ☐ Other (Specify) Alexandria, VA 21. Signature of Funeral Service 22. Name and Address of Facility Le Vol FUNERAL HOME any RACU GRITHFESFURG 7087 M01117 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a con u e of) Examiner depression Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of imply) Examine Due to (or as a co sequence of and and the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or imjury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the burn Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) signed by the atte in the past 12 months? Month Day 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform certificate 1 ☐ Yes 2 ☐ No 2 X No __ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA မ 4 Nursing Home 5 Residence 6 Other (Specify) After this 27 Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 🗌 Natural 5 Pending found₇:05PM 1 Yes 2 Accident
3 Suicide 3/5/2012 Investigation Hanging to the Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Homicide City or Town, State) 430 Girard Street #201; Gaithersburg, Home within 24 hours a Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Om 29018

Registrar

State

10301 Georgia Avenue Suite 104, Silver Spring, MD 20910

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D./DME,

Registrar's Signa

Betsy Ballard

09

31. Date filed (Month, Day, Year,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra AMEND#22 OperMD, 3/13/12; BMW, MCO Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ March 5. 2012 11:57 AM Madelun Elizabeth Coffey Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Montgomery Silver Spring Holy Cross Hospital If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours (Month, Day, Year) **Director** 459-44-4192 1 🗆 M 2 🕱 F 81 1930 Texas May 17, Usual Residence of Deceden or 28a-f show be notified at 10c. City, Town or Location filed within 72 hours after death with the Maryland 10a. State 10b. County 10d. Inside City Limits **Funeral Director** 1 Yes 2 X No Silver Spring MD Montgomery 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? items 23a or ner must be r USA 20902 1500 Billman 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status and 2 should be filed within 72 hours after deat Health and Mental Hygiene. Hen 27 is marked other than "natural", or iter ther traumatic event, the Medical Examiner. Black, White, etc Completed by 1 Never Married 2 X Married 1 ☐ Yes 2 🌠 No If Yes, Give Baltimore, Maryland 21215-0036 Specify:African Americas 1 ☐ Yes 2 X No Specify 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) College Professor Education 5+ Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Marjorie Elizabeth Harris Clifton L. Brewer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1500 Billman Lane, Silver Spring, MD 20902 Gilbert H. Coffey, Jr./Spouse item 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1 🗆 Burial 2 💢 Cremation 3 🗆 Removal from State Brentwood, Maryland 03/13/12 4 ☐ Donation 5 ☐ Other (Specify) Lincoln Crematory 22. Name and Address of Facility Hines-Rinaldi Funeral flome Signature of Funeral Service Licensee 11800 New Hampshire Ave., Silver Spring, MD 2090 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death Immediate Cause (Final disease or condition Septic Shock Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if day, reading to ministrate cause. Enter Underlying Examiner Due to for as a consection of oil To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) attending physiciar Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 month 1 Yes 2 No 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Year Pregnant at time of death 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖔 Unknown Acute Renal Failure Completed 24b. Were autopsy findings available prior to completion of cause of death? Multiple Sclerosis 24a. Was an performed? Yes 2 N 1 Yes 2 No 25. Was case referred to medica funeral director, Be 26. Place of Death (Check only one) examiner? 2 🗶 No Other: မ 1 X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide within 24 hours after dea

To the Funeral Director

completely filled in by th 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) March 5, 2012

Registrar DHMH 17 Rev 06-2011

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jonathan Duran

MAR 0 9 2012

31. Date filed (Month, Day, Year)

D66249

1500 Forest Glen Rd., Silver Spring, MD 20910

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ March 4 2012 12:05 P M Elaine Cochran Dunkle Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Calvert **Examiner** Port Republic 2416 Azalea Road . Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours 1 🗆 M 2 🙀 F 522-26-1683 96 May 14 1915 Perinsylvania Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Calvert Port Republic 1 🗌 Yes 2 🕱 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 2416 Azalea Road 20676 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 11. Marital Status Race - American Indian. Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: white 3 X Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Public Education Teacher Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Alice Blanche Wigley ဂ Arthur Vall Spinosa 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5620 Avonshire Place Apt. L Frederick, Maryland 21703 Peter V. Cochran - son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Metropolitan Funeral Service 03/06/2012 1
Burial 2
Cremation 3
Removal from State Alexandria Virginia 4 Donation 5 Other (Specify) 22. Name and Address of Facility Rausch Funeral Home, PA Signature of Funeral Service Licenses 4405 Broomes Island Rd. Port Republic, MD 20676 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between months Death Immediate Cause (Final Physician/ Lung Cancer disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or i that initiated events physician and s the burial-trans Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 inding pure as t IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 Yes 2 X No Pregnant at time of death Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🙀 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has be irector, page 2 sl autopsy perform death? 1 Yes 2 X No Yes 2 X No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 2 2 XNo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 X Residence 6 Other (Specify 27, Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 X Natural injury 5 Pending 2 Accident
3 Suicide Investigation Director: / 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined City or Town, State within 24 hours a

To the Funeral D

completed filled Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

Certifying Numb Practice of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Numb Practice of the basis of examination and on the cause of the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check **Gertifying Nume Practioner** 29b, Signature ar 29d. Date signed (Month, Day, Year) 29c. License number March 5, 2012 D-16823 30, Name and address Robert J. of Chesapeake Avenue, North Beach, MD 20732 dRW 15

State Registrar 31. Date filed (Month, Day, Year,

32. Registra

Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: Iftien 27 is marked other than "matural", or items; injury or other traumatic event, the Medical Examiner must be a injury or other traumatic event, the Medical Examiner must be a	Funera	11. Marital Status 1 Never Married 2 X Marrie 3 Widowed 4 Divorce	12. Was Decedent Ever in U. Armed Forces? 1 X Yes 2 No of Section 1968–198		If Yes, specify	y Cuba	spanic Origin? (n, Mexican, Pue o specify:	Specify Yes or No- erto Rican, etc.)		14. Race - Americ White, etc.	an Indian, Black, nite
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Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 7 Department of Health and Mental Hygiens Important: If item 27 is marked other than injury or other traumatic event, the <u>Medica</u>	- 1	4 Donation 5 Other Speci 21. Signature of Funeral Service Lic	iy.	CLO	22. Name and		г	Rausch Fu			
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vision of Vital Records, P.O. Box 68760, or Atteoding Physiciae: The law requires that the death certificate be executed three death. When death and the this certificate has been signed by the attending physician and in by the funeral director, page 2 should be detached for use as the burial - transit	Physician/Medical	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregr	nancy 2	Fetal death	3	Ectopic pre	gnancy	- 1	d. Date of delivery Month Delivery	ay Year
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Division To the Hospital or Atteodil within 24 hours after death To the Funeral Director: A completely filled in by the fi		4 Homicide determin		nily H	ome			or Town, St 838 Forest Gle	n Roa	ad , Lusby, MD	
e Hos 24 hc e Fun etely	Medical Cer		ician: To the best of my knowledge								
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١, , , (Name and address of person who Donna M. Vincenti, MD 	o completed cause of death (Item Assistant Medical Exan		900 W Balt	imor	Street Bal	timore, MD 212	223		
10+1	tate	31. Date filed (Month, Day, Year)	32. Registrar's Signatu				5 5 1 5 5 1 5 di				
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10d. Inside City Limits

1 Yes 2 No

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Elizabeth W. DeFerrari March 2012 4:59 p Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Montgomery Brighton Gardens Friendship Heights Chevy Chase 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 1 □ M 2 🛛 F Months Days Hours Min Feb. 9, 1921 91 Canada Director 236-16-4398 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at Page 1 and 2 should be filled within 72 hours after death with the Maryland ment of Health and Mental Hygiene. 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1x Yes 2 □ No Chevy Chase Md. Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5555 Friendship Blvd. 20815 USA 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 1 Never Married 2 Married Completed by 1 Yes Baltimore, Maryland 21215-0036 2 X No 1 ☐ Yes 2 X No Specify: Specify: White "natural", 3 X Widowed 4 ☐ Divorced Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) is marked other than aumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Office Manager Union Carbide Corp. Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be fi Department of Health and Mental Important: If item 27 is marked any injury or other traumatic evonce. ൧ Charles E. Weaver Josephine Hartl 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lisa DeFerrari/ Stepdaughter 1212 N. Inglewood St., Arlington, Va. 22205 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Gate of Heaven
Cemetery 1 X Burial 2 Cremation 3 Removal from State Mar.9,2012 4 Donation 5 Other (Specify) Silver Spring, Md MO1315 22. Name and Address of Facility DeVol Funeral Home 2222 Wisconsin Ave. N.W. Washington. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ Advanced Dementia disease or condition Years Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): an and or Attending Physician: The law requires that the death certificate be executed Cause (Disease or it that initiated events Due to (or as a consequence of) resulting in death) Last physician Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 ast attending IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 🔀 No jo Month Year Pregnant at time of death been signed by the should be detached Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 K No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autops, performed? Yes 2 X No page 2 1 Yes 2 No 25. Was case referred to medica 26. Place of Death (Check only one) funeral director, Be examiner? Hospital Other: 2 🛛 No 1 🗌 Yes ျပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Nother (Spec 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 X Natural 5 Pending injury 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A pmpleted filled in by the fu Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined To the Hospital Medical 🕱 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License numbe 29d. Date signed (Month, Day, Year) D34590 March 6, 2012

State Registrar 7758 Wisconsin Ave. #211 Bethesda, Md.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D

Fried.

MAR 0 9 2012

Ε.

Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First_Middle_Last) 2. Date of Death 3. Time of Death March 6, 2012 Louise Dollymore 10:55 PM 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Manor Care-Potomac Potomac Montgomery Social Security Number 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 579-36-8109 Hours. April 3, 1927 84 PA Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 X No MD Montgomery Kensington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3404 Farragut Avenue 20895 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🔀 No If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. White 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: If Yes Give Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Secretary Scientific Organization 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) John F. Leonard Henrietta Morrison 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Anne Brown/Daughter Trellis Lane, Abingdon, MD 21009 3310 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place March 12 2012 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cemetery Silver Spring, MD Signature of Funeral Service Licenses Francis Address Collins Funeral Home Inc. 500 University Blvd. W. Silver Spring, MD 20901 23a. Part 1. Exter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between

Physician Medical Examiner

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Baltimore, Maryland 21215-0036

Physician/

Examiner

Funeral

Director

ems 23a or 28a-f sh r must be notified a

items

"natural", or item edical Examiner n

er than "natur the Medical I

27 is marked other r traumatic event, th

Department of Health Important: If item 27 any injury or other to once.

Medical

Director

Funeral

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Completed

Be

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and physician at the burial as attending properties of the second signed by has page 2

To the Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760

	Immediate Cause (Final disease or condition	Atherosclerotic Coronary Artery Diseas	se	Onset and Death									
	resulting in death)	Due to (or as a consequence of):											
dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last	b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.											
ompleted by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1												
ted by Pi		contributing to death but not resulting in the underlying cause given in Part I. Accident, COPD, Aortic Stenosis	23e. Did tobacco use contribute to										
Comple			autopsy prior to performed? death?	utopsy findings available completion of cause of									
Be	25. Was case referred to medical examiner?	26. Place of Death (Check or	nly one)										
2	1 Yes 2 No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Xinursing Home	e 5 Residence 6 Other (Spec	eify)									
cate:	27, Manner of Death 1 💆 Natural 5 🗆 Pending	28a. Date of injury (Month, Day, Year) 28b. Time of injury 28c. Injury at work? 28c.	d. Describe how injury occurred										

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

D50534

6858 Old Dominion Drive, #104, McLean, VA 22101

29c. License number

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

March 7, 2012

Registrar DHMH 17 Rev 7/2009

State

within 24 hours after death.

To the Funeral Director: After to appleted filled in by the funeral

Certifi

Medical

3 Suicide

29a. Certifier

4 Homicide

6 Could not be

orners

Thomas Masterson, MD

MAR 0 9 2012

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

determined

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death ^{Day} 20<u>12</u> March 12 Physician/ Mary Katharine Estep 11:10 A M . Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 7625 Estep_Place Charlotte Hali Charles Birthplace (State or Foreign Country) Social Security Numbe 7. Age (In yrs. last birthday **Funeral** If Under 1 Year If Under 24 Hrs. 8. Date of Birth 1 □ M 2 🛣 F Months Hours Min 08/23/193 79 **Director** 2<u>20–28**–**6621</u> Washington, DC Usual Residence of Deceden permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event; the Medical Event. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2X No MD Charles Charlotte Hall 10e. Street and Number 10g. Citizen of What Country? Funeral 7625 Estep Place 20622 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married ģ 1 ☐ Yes 2 X No Specify If Yes, Give Year or Dates White 3 Divorced Specify: Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) Rental Office / Elementary/Seconday (0-12) College (1-4 or 5+) 12th Office Manager Commercial Property Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ Samuel Harry Julia Katharine Thompson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7625 Estep Place, <u> Albert Victor Estep/Husband</u> Charlotte Hall. MD 20622 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place)
St. Mary's Catholic
Church Cemetery Burial 2 Cremation 3 Removal from State 4 Donation 5 Doney (Specify) 03/17/2012 Bryantown, Maryland er ice Licensee 22. Name and Address of Facility 3 anature of uneral Brinsfield-Echols F.H., P.A. #M00817 30195 Three Notch Rd. Charlotte Hall. Part Unter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ 9 disease or condition resulting in death) Medical Due to (or as a consequence of **Examiner** Sequentially list conditions, Examine it any leading to immedicause. Enter Underlying Cause (Disease or iinjury Due to lor as a conse uence of attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ Month Pregnant at time of death 1 Yes 2 ed by the a 9 Unknown ate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 Unknown 1 Yes 2 No Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? certificate 2 No 1 🗌 Yes Be 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) examiner? Hospital: 2 NO မှ 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 28a. Date of injury (Month, Day, Year) 27. Manner of Deat 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Certificate: 1- Natural 2 Accident 5 Pending injury s after death. Investigation filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 24 hours a Medical 29a. Certifier within 24 ho

To the Fune

completed fi Medical Examiner: On the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check the only one) 29d. Date signed (Month, Day, Year) ပ

(5)

State Registrar 30, Name and address of perso

med (Month, Day, Year)

32. Relistrar's Signature

32. Registrar's Signature

Shows S. Salls

completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 11 per fh, g925, 03/29/2012dhb Certificate of Death Reg. No. For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Etta Fridley Mabel 0822 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Western Maryland Regional Med Ctr Cumberla Allegan 8. Date of Birth (Month, Day, Year) If Under 24 Hr 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) Year 6. Sex **Funeral** Months Days Country 220-07-6452 93 Director 1 □ M 2**X** F 1918 11, West Virginia 28a-f shov 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director 1 Yes 2 No Allegany Cumberland MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21502 U.S.A. 13523 Ellerslie Road . Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Never Married 2 Married 1 Yes 2 þ 2 XNo Maryland 21215-0036 1 Yes 2 No Specify: Specify: White 3 Widowed 4X Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) should be filed within 72 h and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) College (1-4 or 5+) Medical Nurse permit. Page 1 and 2 should be filed w Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event; Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٩ Stella M. Borror Daniel P. Emmart 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21 Prospect Square, Cumberland, MD Gregg Getty Attorney Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Mar 19, 2012 Cumberland, MD 4 \square Donation 5 \square Other (Specify) Scarpelli Crematory 22. Name and Address of Facility Hafer Funeral Service, P.A. ture of Funeral Service Licenses 1302 National Hwy., LaVale, MD 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failule. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Ph_sician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Due to (or as a consequence Exami Cause (Disease or injury and -trans that initiated events resulting in death) Last Due to (or as a consequence of) the attending physician a ched for use as the burial-Physician/Medical that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Year Pregnant at time of death Unknown P.0. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ pe Division of Vital Records, Hospital or Attending Physician: The law requires 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? has page 2 1 Yes 2 No Yes 2 No To the Hospital or Attending Physician: I within 24 hours after death.

To the Funeral Director; After this certifics completely filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospita Other: 2 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d, Describe how injury occurred Natural 5 Pending 1 Yes 2 No ☐ Accident☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practitioners To the best of my Inciviledge, death ordered at the time, data and place, and due to the cause(s) and manner as stated 29b. Signature and regna ss of person who completed cause of death (Item 23a) (Type, Print) 1221 E. National Hwy., LaVale, MD Shiv Khanna, M.D. 31. Date filed (Month, Day, Yea 32. Registrar's Signatur MAR 2 3 2012

Registrar

Please Type or Print in Black Indelible Ink: Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene **1 -** For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Year 4:45 P Cecil Funderburk Jr. Medical March 08 201 4a. Facility Name (if not institution, give street and number, Examiner 4b. City, Town, or Location of Death 4c. County of Death Southern Maryland Hospital Clinton Prince George cial Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** 577-88-1575 Days Year) 51 Director 1 **⊠** M 2 □ F 01/08/1961 DC Usual Residence of Dece show at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director notified MD Prince George Temple Hills 28a-f 1 Yes 2 No ö 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be r Funeral 4521 Henderson Road 20748 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Race - American Indian, Black, White, etc. ral", or iter Examiner Armed Forces?
1 ▼ Yes 2 □ No If Yes, Give þ 1 Never Married 2 Married Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black "natural", Completed 3 Widowed 4 Divorced Year or Dates th and Mental Hygiene.
27 is marked other than "natur traumatic event, the Medical. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Military IT Technician Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Cecil Funderburk Sr Botty Jane Kimble 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1300 Waterford Dr. District Heights, MD 20747 Health a Cecilia Brown/Daughter other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 0 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any injury or once. Cumberland, RI 4 ♣ Donation 5 ☐ Other (Specify) Med Cure Inc. 03/15/12 22. Name and Address of Facility Gerald N. Minnich Funeral Home- 305 N. Potomac St. Hagerstown, MD 21740 Signature of Funeral Service License M01613 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death Physician Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner burial-transit and attending physician I for use as the buria Physician/Medical certificate be Box 68760 IF FEMALE: yes, outcome of pregnancy

☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
☐ Pregnant at time of death 5 ☐ Other (specify) ____ 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day been signed by the a should be detached 1 ☐ Yes 2 ☐ Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 M Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an has autopsy performed? After this certificate funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? 2 No Hospital: ᅆ 1 Ninpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred Hospital or Attending Natural Accident 5 Pending 24 hours after death. Funeral Director: A Investigation filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the 6 only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D24208 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) IW-2+1

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 05° Physician/ 2012 ar Marlene Fishbein March 9:00am Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death Hebrew Home of Greater Washington Rockville Montgomery Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Now Votal 8. Date of Birth **Funeral** Months Days June 02 075-16-7084 New York Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "---" any injury or other than "---" الygiene. other than "natural", or items 23a or 28a-f shoy الاستاد Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Rockville Maryland Montaomeru 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20852 6121 Montrose Road U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 Married Completed by 1 ☐ Yes 2 No Specify: 3 X Widowed 4 Divorced Specify Caucasian 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Aaron Anglin Miriam Aronoff 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lakeside Overlook, Rockville, Maryland 20850 Warren Fishbein - Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1 X Burial 2 Cremation 3 X Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 03/09/2012 | Flushing, New York Hebron Cemeteru 21. Signature of Fyneral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on , ch line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examine Due to (or as a consequence of): signed by the attending physician and do be detached for use as the burial-transity To the Hospital or Attending Physician. The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ page 2 should be detached for in the past 12 months?

1 Yes 2 No 1 Yes 2 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2× No 3 Probably 4 Unknown within 24 hours after death.

To the Funeral Director: After this certificate has been Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No completed filled in by the funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? 2 No Other: 1 Yes 4 Nursing Home 5 Residence 6 Other (Specify, 1 Inpatient 2 ER/Outpatient 3 DOA Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 1 Natural
2 Acci 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 Yes 2 No ☐ Àccident ☐ Suicide ☐ Homicide Investigation ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State, Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year)

SITBEIN

32. Registrar's Sig

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2<u>012</u> Month Physician/ Рм 7:30 Katherine <u>Gou</u>naris March Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's <u>Patuxent River Health & Rehab Center</u> Laurel If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthdav) If Under 1 **Funeral** Months Min 094-20-5306 **Director** 1 □ M 2 🏋 F 1914 Dec. 15. Greece 97 Usual Residence of Deceden 28a-f shov 10d. Inside City Limits be notified at 10a. State 10b. County 10c. City, Town or Location Director 1X Yes 2 ☐ No Laurel Maryland Prince George's ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23a ural", or items 23a 20707 USA 7540 S. Arbory Lane 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 X No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify: 3 X Widowed 4 Divorced White Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Home Maker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) and Mental I မ Agnes Diapoulis George Gounaris 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health item 27 Arbory Lane Laurel, MD 20707 Jim Gounaris/ Son 7540 S. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State permit. Page 1
Department of
Important: If it
any injury or o of 1 XXBurial 2 Cremation 3 Removal from State Ormond Beach, Florida 4 ☐ Donation 5 ☐ Other (Specify) Memorial 1 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Robert E. Evans Funeral Home 16000 Annapolis Road Bowie, MD 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Cerebral Thrombosis Minutes Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exam Physician: The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of): physician a s the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE: JSe 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy5 Other (specify) for in the past 12 months?
1 Yes 2 No Month Pregnant at time of death Day Year 1 ☐ Yes ∠ ☐ 9 ☐ Unknown the 9 Unknown signed by to Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 💢 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 X No page 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner's Hospital 2 XNo Other: မ 1 Yes 4 X Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA this (within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral of 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Hospital or Attending Natural Accident 5 Pending Investigation М 1 Yes 2 No 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 3 🗌 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and 29d. Date signed (Month, Day, Year) 3/2/2012

\⁰□

William A.

Registrar
DHMH 17 Rev 06-2011

8871 Gorman Road Laurel, MD 20723

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

Warren,

MAR 08 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

				For State	State of Ma	arylanc		rtment of I tificate of I		and M			0010	00166		
				Registrar 1. Decedent's Name (First, Middle,	Last)		Cer	incate of t	Jeani		2. Date of Dea	Reg. No	0.2012	3. Time of Death		
		Physicia Medic		ROY CALVIN GEI	,						Feb.	ag	ay aola	b:ODA M		
		Examin		4a. Facility Name (if not institution,				4b. City, Town, o		of Death		40	c. County of Death			
	ممسيدا	Funeral				(In yrs. las	t birthday)	Eas'	If Under		8. Date of Birt	th	g, Birth	place (State or Foreign		
		Director		166-28-0133	1 X M 2 □ F 7	6	Yrs.	Months Days	Hours	Min.	JULY 07	y, Year) 1	935 PHIL	ADELPHIA, PA		
,		show dat	្រ	Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Loc	ation						10d. Inside City Limits		
		Maryla 28a-f s atified	Director	MARYLAND TALBOT		TRA	PPE							1 ☐ Yes 2X No		
		h the lagar 2	a Di	10e. Street and Number				10f. Zip Code				10g. C	Citizen of What Cou	ntry?		
		ath wit	Funeral	4418 WHITEMARSE	ROAD 12. Was Decedent Events	ver in II.S	13 M	21673	lisnanic Ori	ain? (Spe	cify Yes or No-	US	SA 14. Race - Americ	can Indian		
	9	filed within 72 hours after death with the Maryland al Hyglene. d other than "natural", or items 23a or 28a-f sho went, the Medical Examiner must be notified at	by Fi	1 Never Married 2 Marrie	Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Never Married 2 Married 1 X Yes 2 No											
>	215-0036	ours af tural", al Exa		3 Widowed 4 Divorced		ITE										
Roy	75	72 hc	Completed	15. Decedent (Specify only highes	Kind of Business In	dustry										
1	7	e filed within 72 hour tal Hygiene. ed other than "natu event, the Medical	ပ္ပ	Elementary/Seconday (0-12)	DUSTRIAL	MACHINIST										
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CT	J.	2 should be th and Men 27 is marke traumatic	ľ	CLAUDE CALVIN 19a. Informant's Name/Relationshi	or Town, State, Zip	Code)										
		- N N		ROY BRUCE GEIST	/ SON		1628 (OSPREY C	IRCLE	CAME	BRIDGE,	MD	21613			
	Baltimore,			20a. Method of Disposition 1 ☐ Burial 2 🏋 Cremation	Location - City or T											
	ij	nit. Page artment c ortant: If injury or e.		4 Donation 5 Other (Sp. 21. Signatur us ral Lice	~		CENTE		i r	1ARCH	3 201	STE	VENSVILLE	, MD		
	B	permit. Departr Importa any inju		17. Kliff	Hypun C	F51		LLOWS, H O SOUTH	ELFEN HARRI	BEIN SON S	& NEWN	AM I EAS:	FUNERAL H TON, MD 2	OME, P.A. 1601		
				23a. Part 1. Enter the disease, or of shock, or heart failure. List on	omplications that caused ly one cau e in each line.	the death.	Do not ente	r the mode of dyir	ng, such as	cardiac o	r respiratory ar	rest,		Approximate Interval Between		
	and the same of	Medical		Immediate Cause (Final disease or condition resulting in death)	a		40 Ca	dial	In	Sar	ction	1_		Onset and Death		
0.0	مد	Examiner			Due to (or as a	. conseque	ence ot):									
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	876	tificate ng phys as the		IF FEMALE;												
	Box 687	ath cer attendi for use	cian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1 Live Birth 2 4 Pregnant at	2 🗌 Fetal	death 3 _	Ectopic pregnan	су			1	23d. Date of deliver Month	rery Day Year		
	. B	the dea	hysi	1 Yes 2 No 9 Unknown	9 Unknown	anno or ac	Julii 0 C									
	. P.O.	requires that the death certific been signed by the attending I should be detached for use as	Completed by Physician/M	Part II. Other significant condition	s contributing to death bu	ut not resu	Iting in the u	nderlying cause g	iven in Part	I.				he cause of death?		
	rds	require	eted	COLLOWIC DOL	5/7001116	1011	conar	4 9/30	430		24a. Was			obably 4 Unknown opsy findings available		
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	a B B	ician: The law certificate has ector, page 2	Be C	25. Was case referred to medical examiner?					lace of Dea	th (Check	1 \(\text{Yes} \)	2	No 1 Yes	ZE NO		
	Zit.	Physician: this certific al director,	은	1 Yes 2 No			R/Outpatien		4 ⊔ N				6 Other (Specif	y)		
	0 0	ttending Phydeath. death. :tor: After this	cate	1 № Natural 5 ☐ Pending		Year)	injury	28c. Inju wor M 1			28d. Describe I	now inju	ary occurred			
	Division of Vital Records,	· Attendil er death. rector: Ai by the fu	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be determined learning determined Suicide 4 Homicide Investigation 3 Suicide 4 Homicide Investigation 3 Suicide 4 Homicide Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Suicide 1 Section (Street and Number or Rural Route Number or Rural Route Number or Rural Route Number or Town, State)												
	Ö	Hospital or Attending Physician: The law requires that the death certificate be executed that hours and the death. Funeral Director. After this certificate has been signed by the attending physician and sted filled in by the funeral director, page 2 should be detached for use as the burial-transities.	Salc											nd.		
		To the Hospital or Attendi within 24 hours after death To the Funeral Director: A completed filled in by the fi	Medical	(Check 2 Medical Ex	Physician: To the best of r aminer: On the basis of ex Nurse Practioner: To the b	amination	and/or invest	igation, in my opin	ion, death o	ccurred at	the time, date a	and plac	ce, and due to the ca	ause(s) and manner stated.		
		To the within 2 To the comple		29b. Signature and title of control				29c. Licens					ate signed (Month,			
		115		and the second	M DO	oth /lts 1	220\ (7: 5	1751	192	>		26	19/12			
		11+VA		30. Name and address of person w	50 -	321	Porch	este A	ve, S	riti	1 (am	bridge,	40 21613		
		Sta		31. Date filed (Month, Day, Year) MAR 0 2 20	2. Registra	r's <i>S</i> ignatu	ire de	U								
		Registr	ar	17AN V & 20	IC Service	ø.	17 000									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month FEBRUARY WILLIAM H. GRANRUTH 2012 M 9:29A Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death 6965 COOKE'S HOPE ROAD EASTON TALBOT 7. Age (In yrs. last birthday) Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Months Min. MARCH Day 8 1935 BALTIMORE Director 213-32-2401 76 Usual Residence of Decedent 28a-f show 10a. State the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 1X Yes 2 No TALBOT EASTON 9 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6965 COOKES HOPE ROAD 21601 USA within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. Il Hygiene. ģ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 😾 No Specify. Specify: WHITE Completed 3 Widowed 4 X Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) -0-WELDER IRON INDUSTRY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be filk Department of Health and Mental I Important: If item 27 is marked o HARRY A. GRANRUTH MABEL MEE WILLIAMS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) KEVIN C. GRANRUTH / SON 28597 EDGEMERE ROAD EASTON, MD 21601 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place 20a, Method of Disposition 1 X Burial 2 Cremation 3 Removal from State WOODLAWN MEMORIAL PARK any injury 4 Donation 5 Other (Specify) 03/03/2012 EASTON, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility EELLOWS HARRISON STREET EASTON, MD 21601 P.A. R. MERCEROD JOHN 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each light Immediate Cause (Final Physician/ disease or condition resulting in death) 40 Cardia Medical Due to (or as a consequence of) Examiner Sequentially list conditions, drug leading to immediate cause. Enter Underlying Cause (Disease or iinjury physician and s the bunal-transit death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last by Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) signed by the ar or Attending Physician; The law requires that the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? perlipldemla Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performe certificate 1 🗌 Yes 2 🗌 No 25. Was case referred to medical funeral director, æ 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home Residence 6 Other (Specify) 1 🗌 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) 27, Manner of Death 28c. Injury at Certificate: 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 24 hours after death. Funeral Director: A 1 🗌 Yes 2 🗌 No ☐ Accident ☐ Suicide the Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Hospital Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completed 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the I within 2 29b. Signature and title of certifi-Day, Year) 20/2 TLS 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) enta MI 31. Date filed (Mor 32. Registrar's Sign

State Registrar

P.O.

of Vital

Division

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2012 Month Physician/ March 10. 6:05 A^M Calvin Coolidge Gardner Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death St. Mary's Charlotte Hall Veterans Home Charlotte Hall 9. Birthplace (State or Foreign 8. Date of Birth If Under 1 Year If Under 24 Hrs. **Funeral** Social Security Number 7. Age (In yrs. last birthday) Hours 12/04/1923 Washington, DC Director 578-20-9849 88 Usual Residence of Decedent 28a-f show 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 ☐ Yes 2 X No St. Mary's MD Charlotte Hall ò 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 20622 USA CHVH, 29449 Charlotte Hall Road within 72 hours after death items 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces? Black, White, etc. "natural", or þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White 3 Divorced If Yes, Give Specify: Completed Year or Dates event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) 11th College (1-4 or 5+) Laundry Service Driver Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Edward Thomas Gardner Mary Elizabeth Vanlandingham 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Sharon Gillespie / Niece 187 Chestnut Trail, Fort Royal, VA 22630 20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date cemetery, crematory or other place, Maryland Veterans Cem: 03/20/2012 Cheltenham, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Brinsfield-Echols F.H., P.A. Funer Pervice Licensyle #M00817 30195 Three Notch Road, Charlotte Hall, MD 20622 23a. Part. Enter he disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death CURDIAR Physician disease or condition Medical resulting in death) Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events and I-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last burial physician Physician/Medical Box 68760 the attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year Pregnant at time of death 1 Yes 2 9 Unknown 2 No 9 Unknown Division of Vital Records, P.O. Part II. Qther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Atrial PIBRI VIAtion 1 Yes 2 No 3 Probably 4 Unknown PARKINSONIS DISEASE ACUTE ROMAL FAILURE . Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy 1 Yes 2 No 1 Yes 2 No certificate 25. Was case referred to medical 26. Place of Death (Check only one) Be 1 ☐ Yes 2 🗹 No Hospital: မြ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this o 4 Nursing Home 5 Residence 6 Other (Specify) 27. Mann of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? 1 Natural 5 Pending iniury within 24 hours after death.

To the Funeral Director: Af
completed filled in by the fu 2 Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature a

Registrar

DHMH 17 Rev 7/2009

Rme

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

31. Date filed (Month, Day, Year)

MAR 1 4 2012

40037228 mp

Stephen Patrick Cafferty, CHVH, 29449 Charlotte Hall Road, Charlotte Hall, MD 20622

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month William Vernon Gipe ARC Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Meritus Medical Center Washington Hagerstown 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Min. (Month, Day, Year) 6/24/1966 Maryland **Director** 213-72-9162 M 2 🗆 F 45 Usual Residence of Decedent 28a-f shov ian "natural", or items 23a or 28a-f sho Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 XYes 2 🗌 No MD Washington <u>Hagerstown</u> 10e. Street and Numbe 10f. Zip Code 10g, Citizen of What Country? Funeral 1017 Lanvale Street 21740 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: 3 Widowed 4 Divorced Completed Year or Dates White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done of life, DO NOT use retired) during most of working al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) the 10 Taxi Cab Driver <u>Transportation</u> Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important; If item 27 is marked oth any injury or other traumatic event ones. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ William Gipe, Sr. Mary Gearldine Mills 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary G. Gipe / Mother 10 Elizabeth Street, Hagerstown, MD 21740 Baltimore, 20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 4 Donation 5 Other (Specify) Smithsburg Crematory 3/20/2012 Smithsburg, Maryland Signature of uneral Service 22. Name and Address of Facility Rest Haven Funeral CHapel 1601 Pennsylvania Ave., Hagerstown, MD 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, Examine If any leading to immedicause. Enter Underlying To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and Cause (Disease or injury that initiated events the burial-tran Due to (or as a consequence of resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? signed by the at Id be detached for Pregnant at time of death Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 K No 3 ☐ Probably 4 ☐ Unknown should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy 2 🗌 No 1 Yes Yes 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) Hospital 1 Yes Other: 2 🔀 No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 □ Yes 2 □ No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Am ola 00070027 3/18/2012 m Campis Rood Hagerstown MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Priot)

State Registrar

Amsler Hau Zia

3 2012

31. Date filed (Month, Day, Year)

11116 Medical

12-01733	O	Please Type or Print in Black					gible.	
Everett William	Gra	otate of Marylana / De			nd Mental Hyg	giene	2	012 0017
DI ST		Registrar 1. Decedent's Name (First, Middle,Last)	Jerunc	ate of Death	10		eg. No.	012 0911
Physici Medical Exam				Creary		Date of Dea Month	Day Ye	3. Time of Death 1748 hrs
		Everett William 4a. Facility Name (if not institution, give street and number)		Gray	or Location of Death	February	29, 2012 4c. County	
		19907 Preference Way		Callaway			St. Mar	
Funeral	7	5. Social Security Number 6. Sex 7. Age (In y	rs. last bir	thday) If Under 1 Ye	ar If Under 24Hrs.	8. Date of Bir	rth(MM/DD/YYY	Y) 9. Birthplace (State or
Director		236-82-7625 1XM 2_F	61	Yrs. Months Da			30/1950	Foreign West Country)Virginia
		Usual Residence of Decedent						"VII ginia
7 any		10a. State 10b. County 10c.	City, Town	or Location				10d. Inside City Limits
and ishov	5	Maryland St. Mary's	Ca]	L1away				1 Yes 2 X No
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t be n	Funeral	11. Marital Status 12. Was Decedent Ever in Armed Forces?	in U.S.	13. Was Decedent of Hi	ispanic Origin? (Spec In, Mexican, Puerto Ri			e - American Indian, Black, e, etc.
r dea	Fur	1 Yes 2 X	lo					White
s affe	by	3 Widowed 4 Divorced If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade completed	d\ 16a	1 Yes 2 X No			Specify:	
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5-00 ed wil sygien other	Con	17. Father's Name (First, Middle, Last)			18.Mother's Name (F	irst, Middle, M	Maiden Surname	9)
21215-0036 uld be filed within 7 Mental Hygiene. marked other than	Be (Everett Gray			Nina	Eator	ı	
D 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-7 she natic event, the Medical Examiner must be notified at once	2	19a. Informant's Name/Relationship (Type, Print)	198	o. Mailing Address (Stre	et and Number or Rur	al Route Num	nber, City or Tow	vn, State, Zip Code)
5 242		Franklin D. Gray/Uncle	:	1007 West Vi	rginia Ave		Martinsh	ourg, WV 25401
ore, I s l and of Healt If item				of Disposition (Name of ce ory or other place) gley- Gardiner		ate		- City or Town, State
Page Page ment innt:		4 Donation 5 Other Specify:	unera	l Home,P.A.Crem	uatory	2/12		dtown, MD
Baltimore, permit. Pages I an Department of He Important: If ite injury or other tr		21. Signature of Funeral Service L ee		22. Name and Addres Mattingle	s of Facility Y-Gardine:	Fune	ral Home	P.A.
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Physician /Medical		failure. List only one cause on each line.				spiratory arre	est, snock, or ne	Between Onset and
Examiner		Immediate Cause (Final disease or condition resulting in death) a. Hypertensive Athero Due to (or as a consequence)		Cardiovascular Dis	sease			Death
		Sequentially list conditions, b	JO 01).					1
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xecuted n and l - transit	Ä	d.						
	lical	UNPENDED AMENDED						
760 cate b	ž	IF FEMALE: 23c. If yes, outcome of p	regnancy	<u> </u>			23d. Date of	delivery
68 certification	Physician/Medi	23b. Was decedent pregnant in the past 12 months?	f death	=	Ectopic pregnancy	,	Month	Day Year
SOX leath e atter for u	iğ.	1 Yes 2 No 9 Unknown 9 Unknown	1 deali 5	Other (Specify)				
D. B. It the de by the ached f		Part II. Other significant conditions contributing to death but n	ot resulting	in the underlying cause of	given in Part I.	23e. Did to	bacco use contri	bute to the cause of death?
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tal Rection: The certificate ector, page		25. Was case referred to medical		26 Place	of Death (Check only	1 Yes 2	2[_]NO 1	Yes 2 No
Vita hysicia this cer	e Be	examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2	ER/Ou	tpatient 3 DOA	Other Nursing H		Residence 6	Other: Scene
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Sion Attendii r death. cctor: /	cation:	1 V Natural 5 Pending 2 Accident Investigation		1,	Yes 2 No			
ivis or At after d Direct	흴	3 Suicide 6 Could not be 28e. Place of Injury - A	t home, fa	rm, street, factory, office b	puilding, etc. 28			er or Rural Route Number, City
Division of Vital Records, P.O. Box 68760, To the Bospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buri	Certifi	4 Homicide determined (Specify)				or Town, St	a.c,	
n 24 h	ᡖ	29a. Certifier 1 Certifying Physician: To the best of my know (Check only 1 Physician: To the best of my know one)	ledge, dea	th occurred at the time, da	ate and place, and due	to the cause	e(s) and manner	as stated.
To the comp	듛	and manner stated.	ri and/or in			e time, date a		
	Σ	29b. Signature and title of certifier		29c. Licens				ed (Month, Day, Year)
		N-WC.		O.C.I	IVI.C.		March 1, 20	J12
8)eme	Į	 Name and address of person who completed cause of death (II Donna M. Vincenti, MD Assistant Medical Ex 	,	900 W Baltimore	Street Raltimor	MD 212	223	
	ate	31. Date filed (Meath Pay Year) 33 Registrar's Sign		Joo vv. Baitimore	Oneet, Daitiiii0i	6, IVID 2 12		
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			State of Maryland / De	partment of Health and M	_							
		•	For	ertificate of Death		Reg. No. 2012 09171						
H	Physicia	n/	1. Decedent's Name (First, Middle, Last)		2. Date of Dea Month	th 3. Time of Death						
40	Medic	al	Rosemary Garrett		Feb.	28,2012 6:45 A ^M						
	Examin	er	4a. Facility Name (If not institution, give street and number) 2318 Parkside Drive	4b. City, Town, or Location of Death		4c. County of Death						
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda		8. Date of Birth							
	Director		072-40-8765 1□M2XF 62 Yrs	Months Days Hours Min.	(Month, Day							
	ind ihow at	'n	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or	Location	IAUG. C	10d. Inside City Limits						
	Maryla 18a-f tified	Director	MD Prince Georges B	Bowie		1 X Yes 2 No						
	h the h	al Di	10e. Street and Number	10f. Zip Code		10g. Citizen of What Country?						
	ms 23	Funeral	2318 Parkside Drive 11 Marital Status 12. Was Decedent Ever in U.S. 1	20721	noify Vac or No-	USA						
ယ	er dea or ite miner	by Fu	11. Marital Status 1 □ Never Married 2 □ Married 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 【XNo	 Was Decedent of Hispanic Origin? (Spin If Yes, specify Cuban, Mexican, Puerto 	Rican, etc.)	14. Race - American Indian, Black, White, etc.						
ğ	ural", I Exal		3 XWidowed 4 ☐ Divorced If Yes, Give Year or Dates.	1 Tes 2 X No Specify:		Specify: Black						
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nd	filed vial Hyg	o Be	17. Father's Name (First, Middle, Last)	18. Mother's Nam	e (First, Middle, I	Maiden Surname)						
Maryland	uld be I Meni marke natic	으	Charles Bryson	Theet		stin						
S S	2 sho Ith and 27 is r traur	1	19a. Informant's Name/Relationship (Type, Print) Maya Garrett/Daughter Boy	ailing Address (Street and Number or Rur 11 River Valley 71e, MD 20720	al Route Number Way	; City or Town, State, Zip Code)						
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 20b. Place of Di	sposition (Name of	Date	20c. Location - City or Town, State						
<u>E</u>	Page ment cant; if ant; if ury or		1 M Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Memori	rematory or other place) RIGGE al Park 3/5/	/12	Elkridge, MD						
Balt	permit Depart Import any in		21. Signature of F meral Service Licensee		oyster Funeral Home ashington, DC 20011							
		Н	23a. Part 1. Enter the disease, or complications that caused the death. Do not									
ولم	hynician/		shock, or heart failure. List only one cause on each line. Immediate Cause (Final			Interval Between Onset and Death						
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687	eath certificate attending phy: d for use as the	/Me	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of delivery						
XO	eath o	iciar	in the past 12 months? 1 Live Birth 2 Fetal death 4 Pregnant at time of death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		Month Day Year						
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ğ	been should	Completed			24a. Was a	an 24b. Were autopsy findings available						
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al	ian; T	Be C	25. Was case referred to medical examiner?	26. Place of Death (Chec		2,20,110						
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Division of Vital Records,	Atter er dea ector by th	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28e. Place of Injury - At home, farm, street, factory, office City or Town, State)										
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	To the Hospital or Attending Physician; The law requires that the death certificate within the translater death. Within 24 hours after death. Completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director, page 2.	Medical	29a. Certifier 1 Check (Check only one) 3 Certifying Physician: To the best of my knowledge, dea only one) 3 Certifying Nurse Practitioner: To the best of my knowledge.	vestigation, in my opinion, death occurred a	t the time, date ar	nd place, and due to the cause(s) and manner stated.						
	To the Hospital or Attending Physician; The law within 24 hours after death. To the Funeral Director: After this certificate has Completely filled in by the funeral director, page 2	2	29b. Signature and title of certifier	29c. License number		29d. Date signed (Month, Day, Year)						
	٦		Cail Pff Ms	D0068056-	MD	2/29/2012						
			30. Name and address of possion who completed cause of death (Item 23a) (Type Elizabeth Pfaffenroth 1221 Merc	29c. License number DOOGBOSG - e, Print) an file Lane, Largo,	MD 20	774						
	Stat		31. Date filed (Month, Day, Year) NAR 0 9 2012	red.								
	Registra	air	MAR UD LUIL Sentin B. 190									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Franklin Hoover Medical Month 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Meritus Medical Center Washington Hagerstown Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Age (In yrs. last birthday) 8. Date of Birth Hours Min. (Month, Day, Year) **Director** 219-14-8162 87 Sept. 22, 1924 Maryland Usual Residence of Decedent 28a-f show 10a. State must be notified at 10c. City, Town or Location Director 1 Tes 2 X No MD Hagerstown Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 320 E. Magnolia Ave. 21742 U.S.A. an "natural", or items Medical Examiner mu Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Wholesale f Health and Mental Hygiene. item 27 is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) the Salesman Food Co. other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Leon Hoover Lillian Shatzer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Reva Jean Hoover/Wife 320 E. Magnolia Ave., Hagerstown, MD 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition Date 20c. Location - City or Town, State Department of H Important: If ite any injury or ot once. 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg Crematory 3/13/2012 Smithsburg, MD 22. Name and Address of Facility Rest Haven Funeral Chapel Signature of Funeral Service Licensee 5 Mlan 1601 Pennsylvania Ave., Hagerstown, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician (ORONARY ARTERT disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner ACUTE dequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine PNEUMONIA the burial-transi Due to (or as a consequence of): attending physician Physician/Medical The law requires that the death certificate be P.O. Box 68760 as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Pregnant at time of death Unknown been signed by the a should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð Division of Vital Records, Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy after death.

Director, After this certificate! 1 ☐ Yes 2 🔀 No 1 Yes 2 No To the Hospital or Attending Physician: funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 🔀 No Hospital Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural Natural injury 5 Pending 1 Yes 2 No completely filled in by the Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number. determined building, etc. (Specify) City or Town, State) Funeral Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier

Registrar
DHMH 17 Rev 06-2011

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1116 Medical Campis Rd. Hagerstown

A212

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

			Please	Type or Pri									_	le.		
		-	For State	State of M	aryland			nt of H e of D		and IV	nental Hy	-	201	2	00	173
			Registrar 1. Decedent's Name (First, Middle, Las	st)		Oei	incat	<u> </u>	Calli		2. Date of De	Reg. No		-	3. Time of	f Death
Ш	Physicia Medio		Marguerite Trip	o Hartman							March	8 ^{Da}	^y 2012	ar 2) A M
	Examin		4a. Facility Name (if not institution, give	street and number)			4b. City	Town, or	Location	of Death		4c. County of Death				
-	/		11721 Mockingbin 5. Social Security Number 6. Social Security Number		- ()	-16545-6-3		gerst	_	Od Um	0.0 : (0)	Washington County				
	Funeral Director		040 40 0000	ex	e (<i>in yr</i> s. <i>i</i> a 92	st birthday)	Months		If Under Hours	Min.	8. Date of Bir (Month, Da	Day, Year) Country)			or Foreign	
	≱ .		Usual Residence of Decedent			Yrs.					July 1	15,1919 Maryland				
	yland -f sho ed at	ctor	10a. State 10b. County	on County		, Town or Loc								100	d. Inside Ci	ity Limits s 2X No
	r 28a notifi	Dire	Maryland Washingto		паде	erstow		p Code				10° C	tizen of What	Country		3 2ALI NO
	within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f show er than "natural", or items 24a or 28a-f show, the Medical Examiner must be notified at	Funeral Director	11721 Mockingbird	1 Lane				21742				-	S.A.	Countr	y :	
	or items	E	11. Marital Status		gin? (Spe	ecify Yes or No- Rican, etc.)		14. Race - A								
36	s after dea ral", or ite Examiner	ğ	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 X If Yes, Give		Specify.		nican, etc.)		Black, V Specify:	hite, et Whi					
8	2 hours aft "natural", edical Exal	Completed by	3 🕅 Widowed 4 🗆 Divorced 15. Decedent's E	Year or Dates.		16a. Deced						405.16				
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	• Hospital or Attending I 24 hours after death. • Funeral Director: After etely filled in by the funer	Medical	29a. Certifier 1 Certifying Phy	rsician: To the best of	f my knowl	edge, death	occurred	at the time	e, date and	d place, a	nd due to the	cause(s) a	ind manner a	is stated	d.	
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			30. Name and address of person who	completed cause of	teath (Itam	23a) /Time 1		יטייכ	637	1 3		11	IHM	1,	1	41
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 20/1 Physician/ 4:50 AM MARCH Betty Lou Hoch Medical 4a. Facility Name (if not institution, give street and number) 4b. City Town, or Location of Death 4c. County of Death Examiner Meritus Medical Center Hagerstown Washington Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 6. Sex **Funeral** Days Hours Min (Month, Day, Year, Director 172-24-9362 1 □ M 2 🗓 F 81 May 23, 1930 Pennsylvania Usual Residence of Deceden 28a-f show 10d. Inside City Limits ms 23a or 28a-f sho must be notified at 10a, State 10b. County 10c. City, Town or Location Director 1 X Yes 2 No Washington Maryland Boonsboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 107 Young Avenue items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Examiner Armed Forces Black, White, etc. P þ 1 Never Married 2 Married 1 ☐ Yes 2 💢 No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 han "natural", o Medical Exam 1 Yes 2 No Specify Specify White Completed 3 X Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) Give kind of work done during most of working nould be filed within 72 and Mental Hygiene. life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) the Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18, Mother's Name (First, Middle, Maiden Surname) ပ George E. Starliper Sarah M. Atherton and l 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 shment of Health a 323 Lanafield Circle, Boonsboro, Maryland 21713 Susan M. Petefish/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place 9 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Department of Important: If any injury or once. 03/15/2012 Hagerstown, Maryland Haven Cemetery 22. Name and Address of Facility e of Funeral Service Licensee Signati Bast-Stauffer Funeral Home, P.A. 7606 Old National Pike, Boonsboro, Maryland 21713 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Ph_sician/ SCUNTE disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Kyphycalion Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) Ortluboronu -tran and that initiated events resulting in death) Last Due to (or as a consequence of): as the burialphysiciar Physician/Medical death certificate be Box 68760 IF FEMALE nse s 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 1 Lyes 2 L 9 Unknown the Linknown P.O. been signed by should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Records, veumonio 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an spital or Attending Physician: The law rours after death.

eral Director: After this certificate has b filled in by the funeral director, page 2 s autopsy performed? death? 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical Division of Vital 26. Place of Death (Check only one) Be examiner? Hospita Other: 1 🗆 Yes ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred (Month, Day, Year) injury 5 Pendina Natural 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide M Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Hospital 24 hours a Medical 29a. Certifier 🔯 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the F 3 only one) 29b. Signat 29c. License number 29d. Date signed (Month, Day, Year) 006

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Registrar

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

14

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 0345 March RANDOLPH A. HUBER 2017 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Easton Talbot Hospital Memorial If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Age (In yrs. last birthday) Months Hours Min 148-32-4044 **Director** 1 X M 2 □ F 71 1/18/1941 NEW JERSEY Usual Residence of Decedent f show with the Maryland ms 23a or 28a-f sho must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🗶 No TALBOT CORDOVA 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 21625 USA 31530 MILLER ROAD 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, traumatic event, the Medical Examiner Black, White, etc. . OF þ 1 Never Married 2 🕅 Married Yes 2 X No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify Specify: WHITE Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) OWNER & OPERATOR 12 0 PRINTING Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ ITA BIZZARI RUDOLPH H. HUBER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra 31530 MILLER ROAD, CORDOVA, GERALDINE F. HUBER, WIFE 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State CHESAPEAKE CREMATION | 3/6/2012 STEVENSVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, 200 SOUTH HARRISON STREET, EASTON, MD 216 iZ. MERCERON CHO P 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ disease or condition Medical resulting in death) Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examir Cause (Disease or injury that initiated events resulting in death) Last the burial-trans Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate I 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ျ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 Yes 2 🔲 No Accident Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 4465656 TLS 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Austr. 219 31. Date filed (Month,

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day 2012 Year Ellen Hess 8, Margaret Mary March a^{M} 4:35 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Medstar Montgomery Medical Center Olney Montgomery 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth **Funeral** Months Days Hours Director 101-10-7107 1 🗆 M 2 🖾 F 96 NY June 12, 1915 Usual Residence of Deced 28a-f show at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Examiner must be notified 1 Yes 2X No Silver Spring MD Montgomery 10e, Street and Numbe 10f. Zip Code 10g. Citizen of What Country? ō 23a Funeral 20904 USA 705 Brantford Avenue items death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. White ö þ 1 Never Married 2 Married 1 Yes 2 If Yes, Give Year or Dates Baltimore, Maryland 21215-0036 72 hours after 1 Yes 2 No Specify Specify: "natural", 3 Widowed 4 Divorced Completed the Medical 15. Decedent's Education Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) giene. College (1-4 or 5+) Elementary/Secondary (0-12) Own Home Homemaker other i other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental F is marked of မ Delia Corbett Michael McEvilly 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 is any injury or other 705 Brantford Avenue, Silver Spring, MD 20904 Alice McGowan/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) March 8, Alexandria, VA 1 Burial 2 X Cremation 3 Removal from State Metropolitan Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility rancis J. Collins Funeral Home Inc. p00 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death .∘h, sician/ disease or condition resulting in death) myocardiu Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of B To the Hospital of Attending Physician; The law requires that the death certificate be executed Cause (Disease or Injury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 phys the t use as attending IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy for in the past 12 months? 5 Other (specify) Month Day Year Pregnant at time of death ed by the a detached i Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ ementia 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of death? l/epressim 24a. Was an cate has to page 2 s autopsy performed? Yes 2 certificate 1 Yes 2 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No ည 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) Manner of Death 28c. Injury at 1 Natural 28b. Time of Certificate: 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director After completely filled in by the funer 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year, Bichhun Uinh 1 754996 March 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Bichwong M. Dinh . 18101 Print Prince Vrive, Olney Philip

State Registrar 31. Date filed (Month, Day,

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32. Registrar's Sía

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2012 18Issac 19:12 Leteneguse Feb Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Medstar Montgomery Medical Olney If Under 1 Year If Under 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 💢 F Months Hours 1277771926 Eritra **Director** 579-19-1310 Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State and 2 should be filed within 72 hours after death with the Maryland Directo 1 🛚 Yes 2 🗌 No Washington DC 10e. Street and Number 10g. Citizen of What Country? Funeral Eritra 20005 1220 12th Street, NW #708 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian of Health and Mental Hygiene.
item 27 is marked other than "natural", or iter
other traumatic event, the Medical Examiner. Black, White, etc. ð 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: 3 Widowed 4 XDivorced Completed Eritraian 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Private Industry Clerk Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည Oqubzqi Ghebreab Mehert Tesfa 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12094 Vicar Woods Lane, Bowie, MD Alem Gheberab/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Page 1 a
Department of P
Important: If ite
any injury or ot 1 X Burial 2 Cremation 3 Removal from State Glenwood Cemetery 2/25/12 Washington, DC 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Frineral Service Licenses 22. Name and Address of Facility Austin Royster FUneral Home 20011 3821 14th Street, NW, Washington, DC 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition 5 Medical resulting in death) Due to (or as consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or linjury that initiated events the Hospital or Attending Physician; The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 - Fetal death 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year Day 5 Other (specify) Pregnant at time of death 1 ☐ Yes 2 ☑ 9 ☐ Unknown detached by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? certificate has been signed I rector, page 2 should be det þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an prior to completion death? performed? Yes 2 2 No 1 🗌 Yes funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No 1 Inpatient 2 ER/Outpatient 3 IDOA မ 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this 28c. Injury at work? 1 □ Yes 2 □ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: Natural 5 Pending Accident Investigation 24 hours after deat Funeral Director: 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 hor To the Fune completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Robert F. Larkin,

18101 Prince Philip Dr. Olney, MD

20832

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day} 2012 Physician/ 12:10 p.^Mm Patrick Jarboe March James Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner St. Mary's Lexington Park 17721 Rosecroft Road 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** Hours Min Director 214-32-8446 1 X M 2 | F 02/25/1934 Maryland 78 Usual Residence of Deceder 10d. Inside City Limits 10b. County 10c. City, Town or Location at Director or 28a-f sl 1 🗌 Yes 2 🔀 No St. Mary's Lexington Park Maryland 10f. Zip Code 10a, Citizen of What Country? 10e. Street and Number ms 23a or must be r ö Funeral Page 1 and 2 should be filed within 72 hours after death with United States 20653 17721 Rosecroft Road items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian "natural", or item ledical Examiner n 11. Marital Status Black, White, etc. 1 Yes 2 No Completed by 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: 3 Widowed 4 Divorced White Year or Dates. 27 is marked other than "natu traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) Mental Hygiene. Medicine Family Physician Be 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) ဂ္ဂ Alma Virginia Hammett Thomas Melvin Jarboe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health a Important: If item 27 is any injury or other trau once. P.O. Box 55, St. Mary's City, MD 20686 Margaret Elizabeth Jarboe/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ▼Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 03/15/2012 Lexington Park, MD St. James Cemetery Edward N. Brinsfield, Jr. M00052 22. Name and Address of Facility Brinsfield Funeral Home 22955 Hollywood Road, Leonardtown, MD 20650 23a, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line EFHRATOR Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or injury MONTH the bunial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last attending physician for use as the buna Be Completed by Physician/Medical LUNG CANCER IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year 9 Unknown 1 L Yes 2 L 9 L Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ARTERI 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform 1 Yes 2 No After this certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: 5 Pending 1 Natural ☐ Accident ☐ Suicide Investigation after death 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined n 24 hour the Funeral Dire

Division of Vital Records, P.O. Box 68760

Baltimore, Maryland 21215-0036

Registrar DHMH 17 Rev 06-2011

State

within 24 ho

To the Fune

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GILL

MD

SHAH

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

□ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
□ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

DS6096

ASSOCIATES HOLLYWGED

29d. Date signed (Month, Day, Year) 3-13-12

MD

20636

12-02155 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Wayne Lloyd James 1- For State Certificate of Death Reg. No Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ 1248 hrs Wavne Llovd James **Medical Examiner** March 15, 2012 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Ocean City Worcester 14402 Tunnel Avenue Apt. 112 If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs. lest birthday) **Funeral** Foreign Country) Hours Months Days Director Sept.26, 1952 218-58-0355 1 X M 2 F 59 Usual Residence of Decedent 10d Inside City Limits 10a. State 10b. County 10c. City. Town or Location MD Worcester Ocean City 1 Yes 2 No show Baltimore, MD 21215-0036
permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 23a-7 sho Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 14402 Tunnel Avenue, Apt. 112 21842 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 Never Married 2 Married 2 X No 1 Yes white 4 X Divorced If Yes, Give Year or Dates: 1 Yes 2 No specify: Specify other than "natural", 2 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) pleted during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) contractor construction 12 Com 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Roscoe L. James Lula Creighton 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 43001 Eustis Street, Chantilly, VA Bryan W. James son 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 20a. Method of Disposition crematory or other place)
Crematory of Delmarva other 1 Burial 2 K Cremation 3 Removal from State 3/19/12 Delmar. DE 4 Donation 5 Other Specify. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility I omas unera ome P.A. 700 Locust St., Cambridge, MD 23a, Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and failure. List only one cause on each line /Medical Death Cardiac Arrhythmia associated with Cardiomegaly Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and G AMENDED 23a, pt.II, 27, per me, g927 5-15-12 sm ficate has been signed by the attending physician (page 2 should be detached for use as the burial X UNPENDED Physician/Medi Division of Vital Records, P.O. Box 68760, 23d. Date of delivery IF FFMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Month 2 Fetal death 3 Ectopic pregnancy Year 1 Live birth Day past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 Yes 2 No 3 Probebly 4 ✔ Unknown Chronic Alcoholism Completed 24a Was an 24b. Were autopsy findings available prior to completion of cause of autopsy Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26.Place of Death (Check only one) examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 Other: Scene this 1 Yes 2 No 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After 27 Manner of Death Certification 1 X Natural 1 Yes 2 No Pending 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Suicide 6 Could not be determined 4 Homicide

Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: A completely filled in by the fun

Sa

State Registrar

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31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a)

29b. Signature and title of certifier

and manner stated

Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

March 16, 2012

OCME

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the besis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra AMEND#2010+querFH, 3/9/12; BWW, McCo Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Month Physician/ 24, 2012 Glynis Johnson Feb 16:57 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Southern Maryland Hospital Prince Georges linton 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign If Under 8. Date of Birth Social Security Number **Funeral** Months Days Hours Min (Month, Day, Year, **Director** 577-90-9342 1 M 2 XF 47 July 15,1964 Wash,DC Usual Residence of Decedent or 28a-f show notified at 10a. State 10c. City, Town or Location 10b. County Director 1X Yes 2 No Prince Georges Clinton MD 10e. Street and Numbe 10f. Zip Code ò 10g. Citizen of What Country? ems 23a or r must be r Funeral 5210 Plata Street 20735 USA items ? 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 1. Marital Status Was Deceden. Armed Forces? ⁴ ☐ Yes 2 X No permit. Page 1 and 2 should be filed within 72 hours after deal Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iter any injury or other traumatic event, the Medical Examiner. Black, White, etc. 1X Never Married 2 Married þ Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. Specify: Black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Teacher Aide Private Industry Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Matthew Coleman Minnie Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gregory Johnson/Brother 2020 Barton Avenue, Richmond, VA <u> 23722</u> Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c Location - City or Town State Waldorf, Maryland Heritage Memorial Glenwood Cemetery 1 X Burial 2 Cremation 3 Removal from State 3-10-2012 4 ☐ Donation 5 ☐ Other (Specify) Washington, D.C. 22. Name and Address of Facility Austin Royster Funeral Home of funeral Service Lie Johns 3821 14th Street, NW, Washington, DC 20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Ph_sician/ estire Cons disease or condition Medical resulting in death) Due to (or as Examiner Gequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine riand and The law requires that the death certificate be executed Due to (or as a consequence of): attending physiciar I for use as the buria Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No 5 Other (specify) Month Dav Year Pregnant at time of death been signed by the sahould be detached Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? b Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? Yes 2 has To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director; After this certificate I 1 Yes Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 No Hospital 1 🗌 Yes 1 d Inpatient 2 ပ ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation mpletely filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 🗜 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Number Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certi 29d. Date signed (Month. Day, Year) 069635

State

Registrar

Ffank Lichtenberger, MD, 7503 Surratts Road, Clinton, MD 20735

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's

31. Date filed (Month, Day, Year)

MAR 0 9 201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? [] [? For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2012 March 5. 6:32 ам Monika Keo Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Washington Adventist Hospital Takoma Park Birthplace (State or Foreign Country) If Under Year If Under 24 Hrs. Social Security Number 8. Date of Birth 7. Age (In yrs. last birthday, **Funeral** Months Days Hours (Month, Day, Year) 536-88-2465 Director 1 M 2 X F Yrs 79 Nov. 17, 1932 Cambodia Usual Residence of Decedent ms 23a or 28a-f show must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "naturoth any injury or other traumatic events." 10d. Inside City Limits 10c. City, Town or Location 10a. State Director 1 Yes 2 No Silver Spring MD Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20903 USA 820 Northampton Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Bace - American Indian. Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 No Specify. Asian 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Own Home 10 Homemaker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Bauv Sun Tea Chhiv Kim Tauch 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 11953 Little Seneca Parkway, Clarksburg, MD 20871 Mony Keo Luong/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 K Burial 2 Cremation 3 Removal from State March 9 Gate of Heaven Cemetery Silver Spring, MD 4 Donation 5 Other (Specify) 2012 Signature of Funeral Service Licensee Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CARSIOMY ORATH Physician/ disease or condition Medical resulting in death) **Examiner** BISCASC Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury the Hospital or Attending Physician; The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last burialphysician a the burial Physician/Medical Division of Vital Records, P.O. Box 68760 as attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ 1 Live Birth
4 Pregnant
9 Unknown in the past 12 months? Year Month Day Pregnant at time of death 1 Yes 2 9 Unknown Yes 2 No been signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? ate has to autopsy performed? 1 Yes 2 No 1 🗌 Yes 2 🗆 No After this certificate Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? 2 X No Other: 4 \(\sum \) Nursing Home \(5 \sum \) Residence \(6 \sum \) Other (Specify, မ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA within 24 hours after death.

To the Funeral Director: After thi

Apmpletely filled in by the funeral Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury 1 Natural 2 Accident 5 Pending 1 Yes 2 No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29c. License number 29d. Date signed (Month, Day, Year) 72944 a 2012 WV. MARCH S

State Registrar Randall P. Wagner, MD

MAR 0.9 2012

31. Date filed (Menth, Day, Year)

DHMH 17 Rev 06-2011

■32. Registrar's Signature

 $_{\Lambda}^{^{of\, death\, (liem 23a)}}$ (Type, Print) Blvd., Germantown, MD 20874

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death March Physician/ V. Lyles Louis Medical 4a. Facility Name (if not institution, give street and number, or Location of Death 4c. County of Death 4b. City. Toy Examiner Plato If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 418-66-5534 **Director** 1 XM 2 □ F Yrs. 65 March 25,1946 SC Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location notified at Director 1 Yes 2 No 28a-f MD Charles Waldorf 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò "natural", or items 23a o Funeral 20603 6221 Kodiak Bear Court United States 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 968 Completed 3 Widowed 4 Divorced Black thand Mental Hygiene.

27 is marked other than "natural"

27 is marked other than "natural" Year or Dates. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Government Accountant Be 18. Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First, Middle, Last) ည Williams Ruby Virge Lyles Louis 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6221 Kodiak Bear Court Waldorf, MD. 20603 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau <u>Cynthia Lyles/wife</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 3/2^{Date} 12 1 X Burial 2 Cremation 3 Removal from State Cheltenham, MD 4 ☐ Donation 5 ☐ Other (Specify) Veterans Cemetery 22. Name and Address of Facility Hodges & Edwards F.H. of Funeral Service Licenses Suitland, MD. 20746 Silver Hill Rd., 3910 Approximate Interval Between Fart . Enter the disease, or complications to shock, or heart failure. List only one cause of Enter the disease, or complications that Immediate Cause (Final disease or condition Ph_sician/ Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): nding physician use as the buria Be Completed by Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 9 I Ilnknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has l autopsy performe 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ျှ 1 🗌 Yes 2 🚺 No 1 M Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this . Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: iniury 5 Pending 1 Yes 2 🗌 No within 24 hours after death. To the Funeral Director: Al Investigation ☐ Accident 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Pertifying Phy Medical Exam To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certi woner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature ar ause of death (Item 23a) (Type, Print) Tarrott State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 11 Day 2012 Year Dona1d LaRocque March 4:38 p.m. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death St. Mary's St. Mary's Hospital Leonardtown Social Security Number . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1**∑** M 2 □ F New York Months Days Hours Min. 12/ 06/ **Director** 76 Ĩ935 122-28-4816 Usual Residence of Decedent or 28a-f show notified at 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 No Tupper Lake New York Franklin ò 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? pe 2 should be filed within 72 hours after death with 1 th and Mental Hygiene. 27 is marked other than "natural", or items 23a traumatic event, the Medical Examiner must b. Funeral 12986 United States 8 Wawbeek Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian, Armed Forces Black, White, etc 1√ Yes 2 No If Yes, Give þ 1 Never Married 2 Married 1 ☐ Yes 2XXNo Specify. Specify: White 3 Widowed 4x Divorced Completed Year or Dates. 1956-60 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Maintenance Hospital Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ophelia Bowrey Adolph LaRocque I and 2 should b I Health and Mer Item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 23503 Lindsay Drive, Leonardtown, Maryland 20650 permit. Page 1 and 2 Department of Health Important: If item 2' any injury or other t Sherrye L. Urtz-Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 03/17/2012 St. Alphonsus Cem Tupper Lake, NY neral Servic 22. Name and Address of Facility Brinsfield Funeral Home Brinsfield M00052 22955 Hollywood Rd., Leonardtown, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ entrucrania Medical resulting in death) Due to (or as a consequence of) **Examiner** ardia Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of the burial-tran and that initiated events Due to (or as a consequence of): resulting in death) Last the attending physician Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Month Day Year 4 Pregnant : 9 Unknown Pregnant at time of death signed by the ar Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Triknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed 2 No 1 Yes Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No ျှ 1 Inpatient 2 ER/Outpatient 3 I DOA Division of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? Hospital or Attending Vatural 5 Pending 24 hours after death. Funeral Director: A 1 Yes 2 No Accident Investigation completed filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation is a stated. Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practiciner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 3 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year)

1 5 2012

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND ITEM#19a, perFH, G926, 4/5/2012, WS State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death RegistramEND #23bperMD, 3/20/12; BMW, McCo Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Losman Ruth Month Day Year Physician/ 2012 8:50P March Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Montgomery Bethesda Suburban Hospital 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Months Days Hours June 24, , 1915 Russia 065-05-9177 96 Director 1 M 2 XF Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10c. City, Town or Location or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a. State 1 X Yes 2 No Potomac Maryland Montgomery Ö 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Numbe Funeral United States of America 12509 Northline Court 20854 death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian 11 Marital Status Armed Forces?

1 Yes 2 No Black, White, etc 1 Never Married 2 Married b Baltimore, Maryland 21215-0036 within 72 hours after 1 Yes 2 No Specify: Specify: Caucasian If Yes, Give 3 XWidowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4 or 5+) Elementary/Secondary (0-12) I Hygiene. Gift Shop Business Owner permit. Page 1 and 2 should be filed wit.
Department of Health and Mental Hygien
Important: If item 27 is many injury any injury and Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Bertha Freid Isaac Rabinowitz 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12509 Northline Court, Potomac MD 20854 19a. Informant's Name/Relationship (Type, Print) Irwin Allen Losman - Son Irvin 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 X Removal from State 4 Donation 5 Other (Specify) David Mem. Gardem 03/07/2012 Falls Church, Virginia King 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hines - Rinaldi Funeral Home, Inc Silver Spring MD 20904 11800 New Hampshire Ave. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph. sician/ disease Chronic Opsmichur Dulmanary disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner bavel Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to lor as a consequence of Dist that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical attending physiciar Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No Month Year Day 1 Yes 2 9 Unknown signed by the a g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ cate has been signed page 2 should be 1 Yes 2 No 3 Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an the Hospital or Attending Physician; The law autopsy performed? 1 ☐ Yes 2 ☐ No this certificate Yes Division of Vital filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 2 No ျှ 1 Yes 1 Npatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred After t work? 1 ☐ Yes 2 ☐ No injury Natural 5 Pending Investigation Accident within 24 hours after death To the Funeral Director: 3 Suicide 4 Homicide 6 Could not be . Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Excertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 2 2012 H67499 05 Chililie (0) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

State

Registrar

Christine Castro

MAR 0 9 201

31. Date filed (Month, Day, Year)

142/00

Losman

8600 Old Georgetown Road, Bethesda MD 20814

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year 1: 50AM 201 danch Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** MERITUS WASHINGTON HAUERSTOWN If Under 1 Year If Under 24 Hrs. Social Security Numbe 7. Age (In yrs. last birthday 8. Date of Birth (Month, Day, Year 9. Birthplace (State or Foreign **Funeral** 220-26-5205 Hours **Director** 1 🙀 M 2 🗆 F 79 Maryland Feb. 8, 1933 Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Hagerstown |Maryland Washington 1X Yes 2 No 10f. Zip Code 21740 10e. Street and Number 10g. Citizen of What Country? Funeral 248 South Prospect Street U.S.A. 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1X Yes 2 No Black, White, etc þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 white 1 Yes 2 X No Specify: If Yes, Give Year or Dates "natural" 3 Divorced 4 Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b, Kind of Business/Industry permit. Page 1 and 2 should be filed within 72 h. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "ns any injury or other traumatic event, the Medic once. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) designer national park service Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Evelyn Jennings ျ John T. Myerly 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 248 South Prospect Street, Hagerstown, Maryland 1740 Judith M. Myerly - wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State March 13, 2012 1

Burial 2

Cremation 3

Removal from State Hagerstown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Hagerstown Crematory 21. Signature of Funeral Service 22. Name and Address of Facility Minnich Funeral Home 415 East Wilson Blvd., Hagerstown, Maryland 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final DISEASE Physician/ HOTERY DRONARY disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** APDIOLENIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to for as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed and -trans that initiated events resulting in death) Last Due to (or as a consequence of): burial physician Physician/Medical PNEUMONI A Box 68760 the as IF FEMALE: use 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 Yes 2 No for Pregnant at time of death Month Day Year detached Unknown P.O. ģ been signed to should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð Records, Completed 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has s certificate has director, page 2 autopsy perform Yes Division of Vital 25. Was case referred to medical director Be 26. Place of Death (Check only one) examiner? 1 🗌 Yes Other: ည 1 ☐ Inpatient 2 🗡 ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After to ompletely filled in by the funer 1X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MEDICAL NEMBOOB DR utn 31. Date filed (Mont 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Corinne Lee Muldoon 1325 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Prince George's Hospital Cheverly . Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Hours (Month, Day, Year) **Director** 578-22-2068 1 🗆 M 2 🗶 F 1925 Washington, DC 86 March 11. Usual Residence of Decedent 28a-f show 10c. City, Town or Location 10d. Inside City Limits ms 23a or 28a-f sho must be notified at Director 1 Yes 2 X No Mary land Prince George's Glenn Dale 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 20769 10905 Patuxent Avenue an "natural", or items Medical Examiner mu death \ 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black White etc. 1 Never Married 2 Married δ Maryland 21215-0036 filed within 72 hours after If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 X Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) the 12 Private Association Bookkeeper of Health and Mental Hygie If item 27 is marked other Ir other traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 and 2 should be Helmer Kallio Helen Harris 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) t of Health a Michael K. Muldoon/ Son 6800 Glen Avenue Glenn Dale, MD 20769 altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20b. Place of Disposition (various)
centerary, crematory or other place)
Gettysburg
National Cemetery

22. Name and Address of Facility Robert E. Evans Funeral Home Page 1 Department of Important: If is any injury or c 1X Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee In fitnis 16000 Annapolis Road Bowie, MD 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician. INTRA · ABDOMINAL HEMORRHAGE disease or condition Medical resulting in death) Due to (or as a consequence of): A HOOD **Examiner** LIVER LACERATION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): MULTIPLE Exami WITH VEHICLE MOTOR COLLISION ician and burial-trans that initiated events resulting in death) Last attending physician Physician/Medical death certificate be Box 68760 as the l IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? signed by the atter d be detached for I Month Pregnant at time of death 1 Yes 2 9 Unknown 9 Unknown P.O. I To the Hospital or Attending Physician: The law requires that the within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy perform 1 ☐ Yes 2 🗷 No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 2 1 No ဂ္ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 🕱 No 1 Natural 2 Accident 5 Pending MOTOR VEHICLE COLLISION MARCH 01, 2013 0900 M Investigation 6 Could not be 3 Suicide
4 Homicide 28f. Location (Street and Number, or Rural Route Number, City or Town, State) BOWIE ROKE AT INTERSECTION OF LAWREL BOWIE ROKE Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined STREET Medical 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗆 only one) 29c. License number 29d. Date signed (Month, Day, Year) D30318 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CATEVENIS, MD 3001 HOSPITAL JAMES 32. Registrar's Signature AR 08 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / Dep		∕lental Hygie	ne	00107
			Registrar	rtificate of Death	Reg.	No. 4 U 1 4	03107
н	Physicia	n/	Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day 2012 Year	3. Time of Death
	Medic	al	Ethel Virginia Mauck	1	March 5		12:40 P ^M
	Examin	er	4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	3.1
and the same	Funeral		Country Home, Ltd. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Harwood If Under 1 Year I If Under 24 Hrs.	8. Date of Birth	Anne Aruno	IEL lace (State or Foreign
	Director		215-16-7074 1 □ M 2 X F 90 Yrs.	Months Days Hours Min.	10-17-19	21 Mary	land
	ě		Usual Residence of Decedent		110 11 27		
	yland f sho ed at	호	10a. State 10b. County 10c. City, Town or Le	ocation		1	0d. Inside City Limits
	28a-	ie	MD Anne Arundel	Harwood			1 🗆 Yes 2 💢 No
	th the	<u>a</u>	10e. Street and Number	10f. Zip Code	10g.	. Citizen of What Coun	try?
	ms 2 mus	Funeral Director	4187 Solomons Island Road	20776	- '/ . V	USA	
'	or ite		11. Marital Status 1	Was Decedent of Hispanic Origin? (Spit Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	14. Race - America Black, White, e	
21215-0036	safte ral', Exan	Completed by	3 X Widowed 4 □ Divorced If Yes, Give Year or Dates.	1 ☐ Yes 2 🔀 No Specify:		Specify: Whi	te
2-0	hour natu dical	Set	15. Decedent's Education 16a. Dece (Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during most of work	168	o. Kind of Business Inc	
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Baltimore, Maryland	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at ance.	To B	17. Father's Name (First, Middle, Last)		ie (First, Middle, Maid		
Ž	should be file and Mental F 7 is marked o raumatic eve		Roland Lester Simpson 19a. Informant's Name/Relationship (Type, Print) 19b. Mail	Emma		Hill	
Ma	12 shouth an and 27 is	ì		ing Address (Street and Number or Rur. 5 3rd Street, Deal			(oae)
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ä	permit Depar Impor any in	- 3		3325 Mt. Harmony L			736
			23a. Part 1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.	ter the mode of dying, such as cardiac	or respiratory arrest,		Approximate Interval Between
F	Ph, sician/	8 7	Immediate Cause (Final disease or condition A / Z Le 1 e S	Discase		,5	Onset and Death
	Medical Examiner		resulting in death) a. Due to (or as a consequence of):	7			1003
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292	icate g physis the	ledi	u.		-		
289	eath certifice attending p	N/U	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 3	□ Catania masaasa		23d. Date of delive	ery
Вох	death e atte	Physician/Medical	1 Yes 2 No 4 Pregnant at time of death 5	Other (specify)		Month	Day Year
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æ	ician: The la certificate ha ector, page				performed	No 1 Yes	2 🗆 No
ita	ysician: is certific director,	Be C	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: Hospital:	26. Place of Death (Chec			
ξV	Phys r this eral di	e:	27. Manner of Death 28a, Date of injury 28b, Time of		ome 5 LI Residence 28d. Describe how in	e 6 X Other (Specify,	Assisted Living
n o	nding nth. : Afte e fune	cat	1 Natural 5 ☐ Pending (Month, Ďay, Year) injury 2 ☐ Accident Investigation	work? M 1 ☐ Yes 2 ☐ No		.,,,	TIATIIA
Division	r Attending F ter death. rector: After by the funera	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm, s' building, etc. (Specify)	reet, factory, office		t and Number or Rural	Route Number,
Ω	tal or A rs after al Direct ed in by				City or Town, S		
	Hospital or Attending Physician: The law requires that the death certificate be executed 44 hours after death. Funeral Director. After this certificate has been signed by the attending physician and ted filled in by the funeral director, page 2 should be detached for use as the burial-transitied filled in by the funeral director, page 2 should be detached for use as the burial-transities.	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death (Check 2 Medical Examiner: On the basis of examination and/or investigation)	occured at the time, date and place, a stigation, in my opinion, death occurred a	nd due to the cause(s	s) and manner as state lace, and due to the cau	d. use(s) and manner stated.
	To the Hospital of within 24 hours af To the Funeral D completed filled in	Me	only one) 3 Certifying Nurse Practioner: To the best of my knowledge 29b. Signature and title of certifier	death occurred at the time, date and pla 29c. License number	ce, and due to the cau	use(s) and manner as st	ated.
	☆ ≯ ☆ ♡		1 Scanna	D3856 3		Date signed (Month, L 1anch 8, 20	
	,		30. Name and address of person who completed cause of death (Item 23a) (Type,	Drint\			^-
de	ki 4		Wayne D. Bicrbaum, m	134 OWERS IN	Mo Rd	Wost	River Mp
	Sta		31. Date filed (Month, Day, Year) 32. Registra 's Signature		V V V		,
	Registr	ar	MAR - 9 2012 Deneur B.	Carles			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death . 2<u>012</u> Month March 8 Physician/ 10:47 Thelma Harrison Morin Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Prince Frederick Calvert Calvert County Nursing Center Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 X Hours July 19, 1934 Washiry D.C. Director 214-30-2246 Usual Residence of Decedent 28a-f show iral", or items 23a or 28a-f shorex Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Calvert Chesapeake Beach 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8015 Delores Ct. 20732 **IISA** within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, þ 1 Never Married 2 Married 1 ☐ Yes If Yes, Give Maryland 21215-0036 White 1 Yes 2 X No Specify. "natural", 3 Widowed 4 X Divorced Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) filed within 72 al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Secretary Police Department Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental I Warren Joseph Harrison Blaisdell ge 1 and 2 should be nt of Health and Men t; If item 27 is marke Marion 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Steven R. Markley 8015 Delores Ct. Chesapeake Beach, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place Date Injury or 1 Burial 2 Cremation 3 Removal from State March 10 Department of Important; If any injury or Lee Crematory 4 ☐ Donation 5 ☐ Other (Specify) 2012 Clinton, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Lee Funeral Home Calvert. Gary 8200 Jennifer Lane Owings, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Dementi disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner eizure Sequentially list conditions, Examine if any, leading to immediate cause Enter or carrying Cause (Disease or linjury that initiated events Due to (or as a consequence of) Due to (or as a consequence of) resulting in death) Last burial attending physician Physician/Medical certificate be Box 68760 as IF FEMALE use yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 9 Unknown 9 Unknown P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 X No death? within 24 hours after death.

To the Funeral Director. After this certificate I completed filled in by the funeral director, page To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 \(\subseteq \text{Yes} Other: 4 X Nursing Home 5 Residence 6 Other (Specify) 2 X No မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate; 28d. Describe how injury occurred 1 X Natural 5 Pending 1 Yes 2 🗆 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 068922 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Vijaya Guduri, MD 130 Hospital Road Ste 300 Prince Frederick, MD 31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

State

Registrar

32. Registra s Signature

MAR 12 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2012 **A**M Gerald Margulies March 2:12 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death <u>Suburban Hospital</u> <u>Bethesda</u> <u>Montaomeru</u> 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Min. Director 1 X M 2 🗆 F 120-16-0353 96 13. 1915 New York Nov. items 23a or 28a-f show her must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Kensington <u>Montgomeru</u> 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3620 Littledale Road 20895 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, injury or other traumatic event, the Medical Examiner Black, White, etc. o þ 1 Never Married 2 Married 1 ☐ Yes 2 If Yes, Give Year or Dates. Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural", Specify: Completed 3 XWidowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry and Mental Hygiene.
is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) 5+ Engineer U.S. Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ <u>Bernard Margulies</u> <u>Bettu Pestes</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other traus <u>Phyllis Smelkinson / Daughter</u> 3001 Veazey Terrace, Apt. 1415, N.W. Wash., DC 20008 Baltimore, 20b. Place of Disposition (Name of Kingne Practical disposition) or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 03/09/2012 | Falls Church, VA Donation 5 Other (Specify) Memorial Gardens Signature of Funeral Service Lace 22. Name and Address of Facility Hines-Rinaldi Funeral Home MU1241 11800 New Hampshire Ave., Silver Spring MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Aspiration Pneumonia disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Dementia Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury To the Hospital or Attending Physician: The law requires that the death certificate be executed Atherosclerotic Heart Disease that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Dysphagia IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 1 Live Birth 2 Fetal death
4 Pregnant at time of death 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Month Day Year 0 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed §€0 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy performed? Yes 2X No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 1 Yes 2 XNo ည 1 X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28c. Injury at 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending work?
1 Yes 2 No Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) ģ 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) edical 29a. Certifier 1🗶 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D53691 March 7. 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ajay Reddy, M 31. Date filed (Month, Day, Year) 3200 Tower Oake Blvd. #110. Rockville. MD 20852 M.D**State** MAR 0 9 201 Registrar

DHMH 17 Rev 06-2011

Division of Vital Records, P.O. Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ^{Day} **2012** Physician/ \mathbf{P} M March 4 7:05 Adele Marie Bolden McQueen Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Kensington Park Retirement Community Kensington Montgomery If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) . Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth **Funeral** 6. Sex (Month, Hours Day Year Director 97 421-40-5777 Feb. 28, 1915 **Texas** Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner managed. 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location Director 1 X Yes 2 No Silver Spring Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3005 South Leisure World 20906 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force Black, White, etc. Yes 2 X No 1 Never Married 2 Married <u>۾</u> Specify: African American 1 Yes 2 No Specify. Completed 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working (Give Rining of work down during most of Resiming Most of Elementary/Seconday (0-12) College (1-4 or 5+) **5**+ Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Unknown Bolden Hattie Mae Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20886 Anita McQueen/Daughter Fern Hollow Way, Montgomery Village, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stat 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Gate of Heaven March 17,2012 Silver Spring, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility McGuire Funeral Service, Inc. 7400 Georgia Avenue, North West Washington, District of Columbia 20012 21. Simulare of Funeral Service Licensee 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Pneumonia Medical Due to (or as a consequence of) Examiner Dementia - Alzheimer's Type Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence on y physician and is the burill-separa Hospital or Attending Physician; The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 attending p for use as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) Yes 2 X No 1 ☐ Yes 2 ☐ Unknown been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 L Unknown Hypertension, Glaucoma, Recurrent Urinary Tract 24b. Were autopsy findings available prior to completion of cause of 24a. Was an Infection page 2 s autopsy performed? death? 1 Yes 2 X No 1 Yes 2 No certificate Be 25. Was case referred to medical director, 26. Place of Death (Check only one) Other: 4 X Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 X No မ 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred After work? 1 Yes 2 No 1 X Natural 5 Pending injury n 24 hours after death.

Ie Funeral Director: A pleted filled in by the fu Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗌 within 2 To the I only one 29b. Signature and title of certifie 29c. License numbe 29d. Date signed (Month, Day, Year) March 7, 2012 **>**D34472 30. Name and address of person who completed cause of death (Itam 23a) (Type, Print) Lynne D. Diggs, 10400 Connecticut Avenue, Suite 206 Kensington, Maryland 20895 M.D. 22. Registrar's Sign State

Registrar

MAR 0 9 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death March 20^{Yea}2 Physician/ 12:30 PM Charles Edward Mason Jr. Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery 1135 University Blvd #410 Silver Spring Birthplace (State or Foreign Country) Social Security Numbe 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) **Funeral** Director 212-32-3664 1 ₹ M 2 □ F 80 April 3,1931 MD "natural", or items 23a or 28a-f show edical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location death with the Maryland Director 1 XYes 2 No MD Montgomery Silver Spring 10f. Zin Code 10g Citizen of What Country? 10e. Street and Number Funeral 20902 1135 University Blvd #410 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 14 Race - American Indian. Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygene. Important: If item 27 is marked other than "natural", or i any injury or other traumatic event, the Medical Examinion à 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify 3 Widowed 4 Divorced Black Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Beneva Farms Dairyman 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) ပ Mary Luvenia Johnson Charles Edward Mason 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5163 Clacton Avenue Camp Springs, MD 20746 Nathan Masson/nephew 20c. Location - City or Town, State 20a. Method of Disposition 3/17712 cemetery, crematory or other place) Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Church Poolesville, MD Paul Comm. 22. Name and Address of Facility Hodges & Edwards F.H. 21. Sign ur of Funeral Service Licensee Suitland, MD. 20746 3910 Silver Hill Rd., 23a. Party: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line, Approximate Interval Between Onset and Death Immediate Cause (Final zus, me Ph_{sician}/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) burial-trans that initiated events Due to (or as a consequence of) resulting in death) Last signed by the attending physician d be detached for use as the burial Physician/Medical or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day Pregnant at time of death 1 Yes 2 L 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 🗌 No 3 Probably 4 Unknown Records, 1 Yes been 24b. Were autopsy findings available prior to completion of cause of 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has autopsy page 2 nerform 1 ☐ Yes 2 No 1 🗌 Yes Division of Vital filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28d. Describe how injury occurred 28c. Injury at work?
1 Yes 2 No iniury 1 Natural 5 Pending Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Hospital Medical LXcertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the only one) 29c. License number 29b. Signature and title of certifier Cu

State Registrar 1299

Lumberton Dr. Silvy Spring, MD 20907

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5K

32. Registrar's

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Physician/ a M 2012 Howard March 17. 3:25 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Williamsport Washington Hasting 16905 6. Sex 0 If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Num Birthplace (State or Foreign
Country) 7. Age (In vrs. last birthday) **Funeral** 216-22-87 Days 1**¥** M 2 □ F Director May 9, 1927 Maryland 84 28a-f shov 10d. Inside City Limits "mit. Page 1 and 2 should be filed within 72 hours after death with the Maryland rearment of Health and Mental Hygiene.
ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location Director 1 🗆 Yes 2 🗀 No Washington Williamsport MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 16905 Hastings Drive 21795 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. ò 1 Never Married 2 Married Yes 1 ☐ Yes 2 No Specify. Saltimore, Maryland 21215-0036 Specify: White If Yes, Give 3 Widowed 4 □ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Custodian Custodial Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Flora May Dunn Chris Preston Mertz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16905 Hasting Drive, Williamsport, MD 21795 Nina Kay Petty / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Rest Haven Cemetery 3/21/2012 Hagerstown, Maryland permit Depart Import any inj once. 21. Signature of Funeral Service 22. Name and Address of Facility Rest Haven Funeral Chapel 1601 Pennsylvania Ave., Hagerstown, MD 21742 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pneumonia Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** bro vascu Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Exami Cardio vascular death certificate be executed and I-tran Due to (or as a consequence of resulting in death) Last burialphysician Physician/Medical Division of Vital Records, P.O. Box 68760 the as attending IF FEMALE: nse 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ 1 ☐ Live Birth 2 ☐ Fetal deat 4 ☐ Pregnant at time of death 9 ☐ Unknown in the past 12 months? for Day Month Year signed by the a 1 Yes 2 9 Unknown Hospital or Attending Physician: The law requires that the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an To the Hospital or Attensions within 24 hours after death.

To the Funeral Director. After this certificate has I autopsy perform death? 2 🗌 No Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 28b. Time of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural injury 5 Pending 1 Yes 2 No Accident Investigation 2 Accident
3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 **Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier R115203 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hospice of Washington County, Hagerstown MD 21742 BarbaraA. Spencer, CRNP . Registrar's Sign

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ 201^{Yea} Mary LaRue Marshall 1:30 P M March 16 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Cecil Rising Sun 100 McNamee Lane Apt. If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Year) 1934 1 □ M 2 🖼 F Months Hours July 30, Country) MD Director 214-32-2754 Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland Director MD Cecil Rising Sun 1 X Yes 2 No 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 21911 U.S.A. 100 McNamee Lane Apt. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? 1 Never Married 2 Married by Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates Specify: Completed 3 ☑ Widowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business Industry al Hygiene. I other than " life. DO NOT use retired) Elementary/Seconday (0-12) 12 College (1-4 or 5+) Administrative Assistant |State Government event, Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event once. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 Barbara Cole Milton Lloyd 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 187 Summit Hill Rd. Quarryville, PA 17566 Shirley J. Urban/Daughter Date 21, 20b. Place of Disposition (Name of 20c. Location - City or Town, State st. Peters Lutheran Cem. Mar 1 K Burial 2 Cremation 3 Removal from State ar. 2012 4 Donation 5 Other (Specify) Hampstead, MD Si shature of Funeral Ser los Lio 22. Name and Address of FacilityJJ Hartenstein Mortuary, Inc 21. 24 N. Second St. New Freedom, PA 17349 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Anemaa SEVER مآ دهم disease or condition Medical resulting in death) ue to (or as a consequence of): Examiner Acuto 6/00d 1099 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Examiner Due to for as a nonsequence of attending physician and for use as the burial-transit Due to (or as a consequence of): Physician/Medical that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?

1 Yes 2 Mo
9 Unknown Month page 2 should be detached for the 9 🗍 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Chronic kidny disease. Division of Vital Records, The law requires 1 🗌 Yes 2 No 3 □ Probably 4 □ Unknown peen s 24b. Were autopsy findings available 24a. Was an autopsy has prior to completion of cause of death? within 24 hours after death.

To the Funeral Director: After this certificate 1 ☐ Yes 2 ☐ No Yes or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 10 2 🗷 No Hospital: 1 Yes 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 ☐ Yes 2 ☐ No the funeral 27. Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred iniury 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by determined City or Town. State) Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗌 only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Meselle 00044373 15 gm 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar Joseph Weidner 101 Colonial Way Rising Sun, MD 21911

32. Registrar's gnatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ March 7, ^{Day}012 Robert Malcolm Morgan 9:45 а м Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery Hospice-Casey House Rockville Montgomery 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Social Security Number If Under 24 Hrs. Hours Min. 038-26-0845 Director 1 🖾 M 2 🗆 F Dec. 31, 1940 Usual Residence of Decedent show 10a. State 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 28a-f 1 Yes 2 X No MD Montgomery 01ney 10e. Street and Number o 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 18904 Willow Grove Road 20832 USA filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 ☑ Yes 2 ☐ No
If Yes, Give 1059 0 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 0 þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 No Specify. ould be filed within and Mental Hygiene.
is marked other than "natural"
... event, the Medical Ey "natural", 3 Widowed 4 Divorced Completed Year or Dates.1958-91 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 5+ Executive Manager Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Robert Tait Morgan Ruth Margaret Muirhead and I 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) . Page 1 and 2 sh ment of Health a tant; If item 27 it Kathleen F. Morgan/Wife 18904 Willow Grove Road, Olney, MD 20832 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State March 2012 Important; If any injury or Alexandria, VA 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory Signature of Funeral Service Licensee Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician Squamous Cell Carcinoma of Head and Neck disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Consequence of Agent Orange Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Spital of titending Physician. The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) use as the burialattending physician Physician/Medical If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) been signed by the s should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Diabetes Mellitus, Type II 1 ☐ Yes 2 🗷 No 3 ☐ Probably 4 ☐ Unknown Completed Ischemic Heart Disease 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Funeral Director After this certificate has In the Funeral Director After this certificate has In the Funeral Director, After the funeral director, page 2. autopsy performed Both Consequence of Agent Orange Yes 2 X No ☐ Yes 2 🔲 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 1 🗌 Yes 2 XNo ျှ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined 🗷 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of my knowledge, death occurred at the time, date and place, and the total course of the total so stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

Contriguing Nurse Prantitioner: To the Sould Try in Sunday, death occurred at the time, date and place, and due to the cause(s) and manner stated

State Registrar

1241

29b. Signature and title of certifier

Bindu Joseph,

MAR 0 9 201

31. Date filed (Month, Day, Year)

30. Name and address of berson who completed cause of death (Item 23a) (Type, Print), #100

MD

29c. License number

D60634

1355 Piccard Drive, Rockville, MD 20850

29d. Date signed (Month, Day, Year)

March 7, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Rimone N. Mufarreh 2012 10:35 March Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Rockville Shady Grove Adventist Hospital Montgomery Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth **Funeral** Days (Month, Day, Year) 64 Yrs. **Director** 320-46-4551 1 **X** M 2 □ F 02/24/1948 Palestine Usual Residence of Deced or 28a-f shov notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director MD Montgomery 1 Tes 2 No Gaithersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? er than "natural", or items 23a of the Medical Examiner must be Funeral U.S.A. 20877 18708 Capella Lane death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. δ 1 Never Married 2 Married 5-0036 1 Yes 2 No Specify. Specify: White If Yes, Give Year or Dates 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry d 2 should be filed within 72 alth and Mental Hygiene.
27 is marked other than ", traumatic event, the Mec Renovations and Elementary/Secondary (0-12) College (1-4 or 5+) Plumber Remodeling Be 18. Mother's Name (First, Middle, Maiden Surname) Maryland 17. Father's Name (First, Middle, Last) ၉ Jamileh Sackleh Nabih Mufarreh I and 2 should be Health and Me 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 18708 Capella Lane, Gaithersburg, Maryland 20877 Important: If item 27 any injury or other tra Nabeel Mufarreh - Son 27 Baltimore, 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date cemetery, crematory or other place, Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 03/09/2012 Silver Spring, Maryland Gate Heaven Cem. 21. Signature of Funeral Service Lice 5600 22. Name and Address of FacilitHines-Rinaldi Funeral Home Inc. 11800 New Hampshire Avenue, Silver Spring, MD 209/04 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of lying, such as car, liac or respir tory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between set and Death Immediate Cause (Final Physician/ OCAI2 disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine or Attending Physician: The law requires that the death certificate be executed the burial too attending physician and Physician/Medical P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year 5 Other (specify) Pregnant at time of death cate has been signed by the a page 2 should be detached. Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Wunknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy this certificate has 2 No 1 Yes funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 1 Yes Certificate: To 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 28d. Describe how injury occurred 5 Pending Natural within 24 hours after death.

To the Funeral Director: A 2 No Accident Investigation Completely filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of 29d. Date signed (Month. Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) William Medical Center Drive, Rockwillt, Mary long 20830 9901 Date filed (Month, Day, Year, 32. Registrar's Signature State Registrar

(0)

NABIH MUFAEREH

JWONE.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 | | | 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ THELMA MC CAWLEY VIRGINIA 2012 MARCH 10 9:30P M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death GENESIS LA PLATA CENTER CHARLES LA PLATA 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 🗆 M 2 🔀 F Months Days Hours (Month, Day, Yea JUN . 15 . 1 1918 WASH. Director 578-03-2286 93 Usual Residence of Decedent 3a or 28a-f show t be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD CHARLES LA PLATA 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? 23a Funeral must 1 MAGNOLIA DRIVE 20646 U.S.A. items . Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) ral", or iten Examiner r 11. Marital Status 14. Race - American Indian, Black, White, etc. 2 1 Never Married 2 Married 1 ☐ Yes 2√ YNo If Yes, Give Baltimore, Maryland 21215-0036 72 hours after 1 ☐ Yes 2 X No Specify "natural", Specify: WHITE 3 X Widowed 4 ☐ Divorced Completed Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry Je filed with... Hall Hygiene... (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) RETAIL CLERK SAFEWAY 10 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, should be file and Mental F is marked o CLARENCE O. MOORE MARY MAGDELINE BOSWELL 1 and 2 should bot Health and Meitem 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARY C. COCHRAN/DAUGHTER 2812 RITCHIE ROAD FORESTVILLE, MD 20747 20a Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a Department of h Important: If ite any injury or ot MARCH 1 Burial 2XXCremation 3 Removal from State METRO • CREMATORY ALEXANDRIA, VA 12, 2012 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licens 22. Name and Address of Facility RAYMOND FUNL. SERVICE, P.A. 5635 WASHINGTON AVE., LA PLATA, MD 20646 1-0n M00641 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Inte Physician/ 1 most disease or condition resulting in death) X'Orage Medical Due to (or as a consequence of): Examiner Sequentially list conditions n any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (of as a consequence of) Examir and -transit that initiated events ng physician ar as the burial-ti resulting in death) Last Due to (or as a consequence of) Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be of Vital Records, P.O. Box 68760 attending p IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Fctopic pregnancy in the past 12 months?

1 Yes 2 No Month Year Pregnant at time of death 5 Other (specify) Day 1 ☐ Yes 2¥ 9 ☐ Unknown signed by the a g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖾 Unknown Completed te has been 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed Yes 2 1 ☐ Yes 2 ☐ No this certifica After this certific funeral director. 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Tes ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28c. Injury at work? 28a. Date of injury 28b. Time of Certificate: 28d. Describe how injury occurred (Month, Day, Year) 1 Natural injury 5 Pending Division n 24 hours after death.

le Funeral Director: Af
pleted filled in by the fu 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 23 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. the only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month. Day, Year) Speins CRNF 700 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 41400 Yellocshington Gaine 31. Date filed (Month, Day, Year) MAR 2 3 2012 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ March 4:21 M 2012 Constance Joann No11 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Meritus Medical Center Washington Hagerstown 5. Social Security Number If Under 24 Hrs. 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours 1/23/1935 Maryland Director 214-30-1836 1 □ M 2 🔀 F 77 Usual Residence of Decedent 28a-f shov 10a. State 10b. County notified at 10c. City, Town or Location 10d. Inside City Limits irector 1 🗌 Yes 2 💢 No MD Washington Hagerstown Ö ò 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Examiner must be Funeral items 23a U.S.A. 10037 Downesville Pike 21740 death v Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 9 by 1 Never Married 2 Married 1 ☐ Yes 2 XNo 72 hours after Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify "natural", Specify: Completed 3 Widowed 4 Divorced White the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) 12 Bank Teller Finance Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ည Joseph A. Long, Sr. Helena Bright Davis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau 10037 Downesville Pike, Hagerstown, Gilbert Noll / Spouse MD 21740 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Donation 5 Other (Specify) Rest Haven Cemetery 3/19/2012 Hagerstown, Maryland A Funeral Service Lice Signature 22. Name and Address of Facility Rest Haven Funeral Chapel Pennsylvania Ave., Hagerstown, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ disease or condition Medical resulting in death) Due to (or as a consequence of **Examiner** Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence o or Attending Physician: The law requires that the death certificate be executed and burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE: use 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ for in the past 12 months? Day Year Pregnant at time of death 2 No 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ be 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy After this certificate 1 Yes 2 No Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospita 1 ☐ Yes 2 No Other: 은 1 N Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, the funeral Manner of Death Date of injury (Month, Day, Year) Certificate: 28b. Time of 1 Natural 28c. Injury at 28d. Describe how injury occurred work?
1 \(\superset \text{Yes} \quad 2 \superset \text{No} \) 5 Pending iniury s after death. Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Location (Street and Number or Rural Route Number, determined City or Town, State) Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check within 2

To the F 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 29d. Date signed (Month. Day, Year) 0063

State Registrar 530

Northern

21742

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MID

32. Registrar's

Mahowood

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 1 tem 5 per 1 th 2933 11-7-12 vt State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month 4 A Physician/ Mary Sue Nandor 30 PM Maril 2012 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Washington County 13526 Paradise Dr. Hagerstown Social Se**28**y Number 515-18-1002 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** 78 1 □ M 2 🛛 F Director Feb. 6,1934 Oklahoma Usual Residence of Decedent show or 28a-f shov notified at 10d. Inside City Limits 10c. City, Town or Location Director Maryland Washington County 1 Yes 2 X No Hagerstown 10f. Zip Code 10g. Citizen of What Country? ò er than "natural", or items 23a of the Medical Examiner must be Funeral 21742 13526 Paradise Dr. U.S.A. within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married þ Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White If Yes, Give 3 XWidowed 4 ☐ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any injury or other traumatic event, the Mexonce. Elementary/Secondary (0-12) College (1-4 or 5+) Store Manager Retail Co. Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Tishev Alice Ballard Joseph James Bowers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1750 Starcross Rd. York, PA 17403 Deborah Nandor-Levin-daughter 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State 3-17-2012 Rose Hill Cemetery Donation 5 Other (Specify) Hagerstown, MD Signature of Funeral Service Licenses 22. Name and Address of Facility Douglas A. Fiery Funeral Home 1331 Eastern Blvd. North Hagerstown, MD 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pfrysician/ disease or condition Un Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) requires that the death certificate be executed and the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last the attending physician Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE: detached for use 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year Pregnant at time of death 2 No g Unknown g Unknown ate has been signed by page 2 should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Myusilis 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 1 ☐ Yes 2 ☐ No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home & Residence 6 Other (Specify) Hospital 1 Yes 2 No ျာ 1 Inpatient 2 ER/Outpatient 3 DOA this To the Hospital to recommend thin 24 hours after death.

To the Funeral Director: After this manufately filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending ☐ Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Medical Campus Idasershown My mack 105 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2012 09199 State of Maryland / Department of Health and Mental Hygiene

	1- For State Certific Registrar	cate of Death	Reg. No.	
Physician/ Modical Examiner	Decedent's Name (First, Middle,Last)		2. Date of Death Month Day Y March 10, 2012	3. Time of Death 1138 hrs
Marrical Examiner	Kenneth Earl Neal 4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of De		y of Death
	738 Medway Road	Hagerstown	Washi	
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last bi		14:-	Foreign
Director	212-50-8162 ₁ M _{M 2} F 58	Yrs. Months Days Hours	Min. 6/9/1953	CountryMaryland
any	Usual Residence of Decedent 10a. State 10b. County 10c. City, Tow	n or Location		10d. Inside City Limits
*		San Francisco		1 Yes 2 No
the Maryland a or 28a-f sh tified at once Director	10e, Street and Number	10f. Zip Code	10g. Citizen of V	What Country?
3a or otifice	579 Burnett Avenue	94131	U.S.A	•
r death with the Maryland or items 23a or 28a-f show must be notified at once. Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. 1 Never Married 2 Married Armed Forces?	13. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pu		ce - American Indian, Black, ite, etc.
ter des Fr mu	1 Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year	1 Yes 2 No specify:	Specify	White
ours afte atural" samine	or Dates:	Decedent's Usual Occupation (Give kind during most of working life, DO NOT use	of work done 16b. Kind of I	Business/Industry
5-0036 ed within 72 hour tygiene. other than "natu the Medical Exan Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	ŭ ŭ	retired)	
1 withing giene.	12 17. Father's Name (First, Middle, Last)	Pressman 18 Mother's Na	Priz ame (First, Middle, Maiden Surnan	nting
215-0036 be filed within 7 ntal Hygiene. rked other than ent, the Medica Be Comple	Henry Bascum Neal		h Marie Lambert	· ·· /
21) bould the mar is mar ritie eve		9b. Mailing Address (Street and Number	or Rural Route Number, City or To	
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	Deborah Sayles / Sister 20a Method of Disposition 20b. Place	111 Windy Hollow Rd	., Fairview, NC	28730 n - City or Town, State
Baltimore, permit. Pages I as Department of Hes Important: If ite	1 Burial 2 Cremation 3 Removal from State crema	atory or other place)		
Itim ii Pa	4 Donation 5 Other Specify: Smiths 21. Shinature of Funeral Service Licenses	Sburg Crematory 3	/14/2012 Smiths	sburg. Maryland
Dep Dep Dep	Knea M. Mittle		Rest Haven Fund nia Ave., Hagers	eral Chapel stown, MD 21742
Physician	23a. Part I. Enter the disease, or complications that caused the death. Do r failure. List only one cause on each line.	not enter the mode of dying, such as cardia	ac or respiratory arrest, shock, or h	Approximate Interval Between Onset and
/// // // // Examiner	Immediate Cause (Final disease or condition resulting in death)	ic Cardiovascular Disease		Death
	or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, b.			
iner	if any, leading to immediate Due to (or as a consequence of):			<u> </u>
ted nsit	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):			
ecuted and and	d.	· · · · · · · · · - · · · · · · · · · ·		
D. Box 68760, It the death certificate be executed by the attending physician and ached for use as the burial - transi Physician/Medical E)	UNPENDED AMENDED			
3876 rtificat ing ph as the		/ 2 ☐ Fetal death 3 ☐ Ectopic pre	gnancy 23d. Date	Day Year
b. Box 687 the death certific by the attending p ched for use as th		5 Other (Specify)		
O. But the d	Part II. Other significant conditions contributing to death but not resulting	ng in the underlying cause given in Part I.	23e, Did tobacco use con	tribute to the cause of death?
i, P.(Hypercholesterolemia		1 Yes 2 No	3 Probably 4 🗹 Unknown
ords w requ is been should			autopsy	Were autopsy findings available prior to completion of cause of
tal Records, P.O. eian: The law requires that the certificate has been signed by ector, page 2 should be detach Be Completed by P			performed? 1 Yes 2 ✔ No	death? 1 Yes 2 No
Division of Vital Records, P.O. ral or Attending Physician: The law requires that the ray after death. al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detable artification: To Be Completed by F	25. Was case referred to medical examiner? Hospital: 1 Inpution 1 2 EB/6	26.Place of Death (Che		
n of Viting Physical After this funeral dir	1 ✓ Yes 2 No	Outpatient 3 DOA Other A Nu Time of Injury 28c. Injury at Work?	rsing Home 5 Residence 6 28d. Describe how injury occu	
ion (tending eath. tor: At the fur	Natural 5 Pending	1 Yes 2 No		
Division o spital or Attending tours after death. Geral Director: Aft filled in by the func	3 Suicide 6 Could not be 28e. Place of Injury - At home,	farm, street, factory, office building, etc.	28f. Location (Street and Num or Town, State)	ber or Rural Route Number, City
Dospital hours noeral y filled	4 Homicide determined (Specify) 29a. Certifier 4 Control of Developing Total of the large transfer of the lar			
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Fuoeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - trans Medical Certification: To Be Completed by Physician/Medical E.	(Check only one) 2 Medical Examiner: On the basis of examination and/or			
Ne de la	29b. Signature and title of certifier	29c. License number	29d. Date sig	ned (Month, Day, Year)
	(alsel 1 1/1)	O.C.M.E.	March 11	, 2012
711-7	30. Name and address of person who completed cause of death (Item 23a)	1/	ro MD 21222	-
₩-2 State	Zabiullah Ali, M.D. Assistant Medical Examiner 9 31. Date filed (Month, Day Year) 32. Registra's Signature	OU VV. DAILIMOTE STREET, BAITIMO	IE, WID 21223	
Registrar	MAR 14 2012	1 Black		
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			for State OTN State Registrar		tificate of L			Reg. No. 20	12	09200
	Physicia	n/	1. Decedent's Name (First, Middle, Last)				2. Date of Dea		Year	3. Time of Death
*	Medic		Lucille Marie Oals		1		03-0	7-2012		11:30AM
	Examin	er	4a. Facility Name (if not institution, give street and number) 122 Armstrong Avenue			r Location of Death de Grac	е	4c. County Ha	of Death rfor	d
- 4-5	Funeral Director		5. Social Security Number 6. Sex 7. A 215-34-0959 1 M 2 X F	ge (In yrs. last birthday) 74 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs.	8. Date of Birth (Mgnth, Day 0 3 / 3 1 /		9. Birthpl Countr Mary	ace (State or Foreign Land
	a-f show fied at	Director	Usual Residence of Decedent 10a. State 10b. County Maryland Harford	10c. City, Town or Loc Havre	de Grac	ce			10	d. Inside City Limits
	vith the Ma 23a or 28 st be noti		10e. Street and Number 122 Armstrong Avenue		10f. Zip Code 21078	3		Onlived of Ame		
036	s filed within 72 hours after death with the Manyland tal Hygiene. ed other than "natural", or items 23a or 28a-f show other, the Medical Examiner must be notified at	ed by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ▼ Widowed 4 □ Divorced 12. Was Decedent Armed Forces 1 □ Yes 2 ▼ If Yes, Give Year or Dates.	? I No	Was Decedent of H f Yes, specify Cuba 1 ☐ Yes 2 🎇 No	ispanic Origin? (Spe an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Rac	e - America ck, White, e	n Indian,
21215-0036	within 72 hou giene. ner than "natu t, the Medical	Completed by	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or	(Give I 5+)	dent's Usual Occup kind of work done o O NOT use retired) etary	during most of worki	ing	16b. Kind of B	usiness/Ind	ustry
	ould be filed wind Mental Hygie marked other matic event, t	To Be (12 17. Father's Name (First, Middle, Last) James McDaniel	Secre	ecary	18. Mother's Name Bertha	e (First, Middle, i Eliza			
, Maryland	1 and 2 should be of Health and Men item 27 is marke other traumatic		19a. Informant's Name/Relationship (Type, Print) Teri Wright (daughter)	19b. Mailir 137	ng Address (Street	and Number or Rura e Drive,	Route Number Perry	; City or Town, S	State, Zip Co MD	21903
Baltimore,			20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Removal from Stat 4 □ Donation 5 □ Other (Specify)	20b. Place of Dispo cemetery, cren Angel Hi		1	Oate /10/12	Havre	7 ~	
Balt	permit. Page Department of Important: If any injury or once.		21. Signaturus al Service Defrice	1	2. Name and Addre	^{ss of Facility} Zel ashingto	lman E	unera. Havre	l Hom e de	e, P.A. Grace, MD
, Alika	Physician/ Medical	2 1	23a. Part 1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each li Immediate Cause (Final disease or condition resulting in death)	ed the death. Do not entene.	er the mode of dyin	g, such as cardiac c	or respiratory arr	est,		Approximate Interval Between Onset and Death
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	executed an and rial-transit	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events c.	s a consequence of):						<u></u>
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s, P.O	uires that the signed by	ed by Pr	Part II. Other significant conditions contributing to death	but not resulting in the u	underlying cause gi	ven in Part I.		obacco use cont Yes 2 🗆 No		e cause of death?
of Vital Records,	Physician: The law requires that the this certificate has been signed by the ral director, page 2 should be detach	Completed by					24a. Was autop	rmed?	Were autop prior to con death? 1 Yes	sy findings available apletion of cause of
a	ian: T	Be C	25. Was case referred to medical examiner?		26. P	lace of Death (Check				
Ξ	Physic this ce ral dire	2	1 🗆 Yes 2 🗖 No Hospital: 1 🗆 Inpa	tient 2 ER/Outpatier		4 L Nursing Ho				
0	ing After fune	Certificate:	Manner of Death 28a. Date of in Month, D 2 Accident Investigation 3 Suicide 6 Could not be Could not be	ay, Year) injury	M 1 🗆	⟨? Yes 2 □ No	28d. Describe h			Pauta Numbar
Division	Hospital or Attend 24 hours after death Funeral Director: /		4 Horniciae determined building, 6	njury - At home, farm, stre etc. (Specify)			28f. Location (S City or Tow	n, State)		
	To the Hospital within 24 hours a To the Funeral I completely filled	Medical	(Check only one) 3 Certifying Nurse Practitioner: To	examination and/or invest	tigation, in my opinion, death occurred at	on, death occurred at the time, date and pla	t the time, date a	nd place, and du he cause(s) and r	e to the cau manner as st	se(s) and manner stated.
	Norition of the contract of th		29b. Signature and title of certifier	MD	29c. Licens	e number 0979		29d. Date signe	(Month, D	ay, Year)
_			30. Name and address of person who completed cause of M., Chg.R. & D.V. 2	53 (Jen	USS LIL	Have	ne ol	a Ga	aco	21078
	Sta Registr		31. Date filed (Mon NARYen) 2 2012 32 segis	trar's Signatur						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Mar 16 Day 2012 Physician/ 0845 **Phillips** Gerald Albert Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** Allegany Allegany Co. Health Nurs. & Rehab. Ctr Cumberland 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) 1 Year If Under 24 Hrs **Funeral** Director 215-26-6568 Usual Re 28a-f shov 10c. City, Town or Location 10d. Inside City Limits 10a. State within 72 hours after death with the Maryland item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at Director Cumberland MD Allegany 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 21502 USA 730 Furnace Street 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14, Race - American Indian, 11. Marital Status Armed Forces?

1 XYes 2 No þ 1 Never Married 2 X Married Maryland 21215-0036 1 Yes 2 No Specify: If Yes Give Specify. 3 Widowed 4 Divorced white Completed WW II Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Columbia Gas Co Engineer Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Page 1 and 2 should be file ment of Health and Mental I ant: If item 27 is marked o ည Anna E. Brown Leslie Phillips 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MD 21740 Hagerstown **Betty Phillips** 232 Nottingham Road wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ò 3/20/2012 MD Sunset Memorial Park Cumberland 22. Name and Address of Eacility
Scarpelli Funeral Home, PA f Funeral Service Licenses 108 Virginia Avenue: Cumberland, MD 21502 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician ARDIAC disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Physician/Medical Examiner the burial-transit or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) resulting in death) Last attending physician Division of Vital Records, P.O. Box 68760 for use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Month Year 5 Other (specify) Pregnant at time of death page 2 should be detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has certificate 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) Other: 1 Tyes 2 🗹 No 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA မ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 🗹 Natural 5 Pending 1 Yes 2 No Accident Suicide Investigation Could not be a er decth the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours arer de To the Funeral Directo completed filled in by t 4 Homicide determined To the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signatuy 29d. Date signed (Month, Day, Year) Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)
NAR 2 3 2012

rera Jr. M.D. 200 Glenn

32. Registrar's Signat

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 1 per doc 9926 4-5-12 yt. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Physician/ Month Year Mary Jeame Potts Mary Jeane Potts 201 navel Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Meritus Medical Center Washington County Hagerstown 8. Date of Birth (Month, Day, Year)
Oct. 27,1936 Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 217-30-6445 **Director** 1 □ M 2 🗶 F 75 Maryland Usual Residence of Decedent or 28a-f show notified at 10c. City, Town or Location 10d. Inside City Limits Director Maryland | Washington County Hagerstown 1 Yes 2 XNo 10e. Street and Number 9 10f. Zip Code 10g. Citizen of What Country? ıral", or items 23a or Examiner must be Funeral 100 Birch Knoll Rd. 21742 U.S.A. Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. δ 1 Never Married 2 X Married 1 Yes 2 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: "natural", Specify: White Completed 3 Widowed 4 Divorced Year or Dates Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) the Homemaker Personal Residence Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Franklin Edward Hovis Pauline Louis Fouke 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health a item 27 i Samuel T. Potts-husband 100 Birch Knoll Rd. Hagerstown, MD 21742 Department of Healt Important: If item 2 any injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place)

Cedar Lawn Mem. Park 3-15-2012 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hagerstown, MD 21 Semalura f Funeral Service License 22. Name and Address of Facility Douglas A. Fiery Funeral Home 1331 Eastern Blvd. North Hagerstown, MD 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a cons * uence of) Examiner Sequentially list conditions, Examine cause. Enter Underlying for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical P.O. Box 68760 yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month been signed by the a should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Division of Vital Records, No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy after death.

Director: After this certificate Yes 2 No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: filled in by the funeral director, 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? No No Other: 1 🗌 Yes 4 Nursing Home 5 Residence 6 Other (Specify, Nnpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined City or Town, State) within 24 hours a To the Funeral C Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 30 6 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 50 State Registrar

12-01637 Michael Polsín

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2012 09203 1- For State Certificate of Death Reg. No Registrar 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Month Day February 26, 2012 0345 hrs Medical Examiner Michael James Polsin 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death St. Marv's 24602 Blackistone Road Hollywood 5. Social Security Number If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min Director CountryWisconsin 05/24/1959 1 🗙 M 2 🔙 F 52 516-84-2221 Usual Residence of Decedent III 10a. State 10b. County 10c. City, Town or Location 10d Inside City Limits 1 Yes 2 X No show Hollvwood Maryland St. Mary's permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f aho hijury or other reamafte event, the Medical Examiner must be notified at once. Director 10e, Street and Number 10g. Citizen of What Country? 10f. Zip Code United States 20636 24602 Blackistone Road 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? White, etc. 1 Never Married 2 Married 1X Yes 2 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No specify: Specify: White Š 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Medical 5+Nurse 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Nancy H. Wickert James H. Polsin

19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 753 NE Pincrest Dr., Bremerton, WA 98311 Tim Polsin/Brother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State crematory or other place) 1 Burial 2 Cremation 3 Removal from State 03/13/2012 Charlotte Hall, MD Donation 5 Other Specify. Brinsfield-Echols Cre 22. Name and Address of Facility 21. Signature of Funeral Service Licens Brinsfield Funeral Home 22955 Hollywood Road, Leonardtown, MD Brinsfield, Jr. M00052 20650 23a, Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and failure. List only one cause on each line Medica Death a Alcohol and Narcotic Intoxication Ėxaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. Due to (or as a consequence of): Examiner if any, leading to immediate cause Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and Physician/Medical AMENDED 23a, 27, 28a-f, per me, g925 3-29-12 sm X UNPENDED attending physician or use as the burial -28e per me g926 4-6-12 vt The law requires that the death certificate be Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant in the 2 Fetal death Month Live birth 3 Ectopic pregnancy Day Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. Š 1 Yes 2 No 3 Probably 4 ✔ Unknown Completed 24b. Were autoosy findings available 24a Was an prior to completion of cause of autopsy certificate has performed . death? ✓ Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26.Place of Death (Check only one) Division of Vital Be Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other 4 Nursing Home 5 Residence 6 ✔ Other: Scene After this 1 🗸 Yes 2 No 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural I Director: / 5 Pending 1 Yes 2 X No unknown fd 2-26-12 fd 3:45 am Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f, Location (Street and Number or Rural Route Number, City 6 X Could not be 3 Suicide or Town, State) 24602 Blackstone Rd Hollywood MD. Blackstone Residence (Specify) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: on the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. February 26, 2012 OCME 30. Name and address of person who complete cause of death (Item 23a) Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 Theodore M. King, Jr., MD. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NAR 19 201 Registrar

ORIGINAL

12-01852 Carla Pinkney Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

arla Pinkney	R	State of Maryland / Department of Health and Mental Hyglene 1-For State Certificate of Death Reg. No.	09201
Physician Medical Examine	7	1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time	of Death iO hrs
	4	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Johns Hopkins Hospital 4c. County of Death Baltimore	
Funeral Director	4	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (1974) 1 Months Days Hours Min. 04/29/1971 Foreign Country)	
yas	_	Tod. Gally Tob. Godiny	side City Limits
		MD Baltimore 11X_1 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?	Yes 2 No
with the Maryland ns 23a or 28a-f sho be notified at once.		2810 Jefferson Street 21205 USA	
er death		11. Marital Status 1 Never Married 2 Married 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American India White, etc. 15. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 16. Race - American India White, etc.	an, Black,
1215-0036 Id be filed within 72 hours at fental Hygiene. narked other than "natural event, the Medical Examin	Completed by	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 15. Decedent's Usual Dccupation (Give kind of work done during most of working life. DO NOT use retired) Never Worked N/A	
21215-0036 Muld be filed within 7 Mental Hygiene. marked other than c event, the Medica	E CO	17. Father's Name (First, Middle, Last) Rudolph C. Jones, Jr. Rosetta Johnson	
D 2121(should be fill and Mental I. 7 is marked natic event, 1	0	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Cool 19c. Do. Box 541 Lusby, MD 20657	de)
imore, MD 2 Pages 1 and 2 shoul nent of Health and N lant: If item 27 is m or other traumatic		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Holland Cemetery 3/10/2012 Hintingtown	
Baltimore, MI permit. Pages 1 and 2 s Department of Health a Important: If iten 27 injury or other traum		4 Donation 5 Other Specify. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Sewell Funeral Home, 1451 Dares Beach Rd. Prince Fred., M	P.A.
Physician Medical	+	23a Part I Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Appro	oximate Interval een Onset and Death
xaminer		Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):	Death
		Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):	
ted i ansit	Ka LXa	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last d. Due to (or as a consequence of):	
b0, te be executed ysician and burial - transit	edicai	UNPENDED AMENDED # 23aPtI per me,g927,05/11/2012dhb	
Division of Vital Records, P.O. Box 6876C To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending phys completely filled in by the funeral director, page 2 should be detached for use as the by the complete of the control of the	5	IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1	Year
.O. B hat the de ed by the letached	9 5	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of the ca	
w requires that is been signed should be det	eted	Obesity, endstage renal disease 24a. Was an autopsy prior to completic	ndings available
Recor The law cate has page 2 sh	Completed	performed? death? 1 ✓ Yes 2 No 1 ✓ Yes	2 No
Vital Recysician: The linis certificate director, page	8	25. Was case referred to medical examiner? 1 Ves 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other 4 Nursing Home 5 Residence 6 Other:	
ding Phy	٥ ا	27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred	
Division of Vital Records, P.O. To the Hospital or Attending Physician: The law requires that th within 24 hours after death To the Functral Director: After this certificate has been signed by completely filled in by the funeral director, page 2 should be detact	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify) 28e Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route or Town, State)	e Number, City
Di To the Hospital within 24 hours a To the Funeral I completely filled	ल	29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)	(s)
To cor	ğ Z	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, O.C.M.E. March 6, 2012	, Year)
		30 Name and address of person who completed cause of death (Item 23a)	
kw 3		Zabiullah Ali, M.D. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 31. Date filed (Month, Day Year) 32. Registrar's Signature	
Stat Registra	12.		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month $20\overset{\text{Year}}{12}$ Physician/ 10:00 PM March Pollin Patricia Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Calvert Prince Frederick Calvert County Nursing Center 9. Birthplace (State or Foreign Country) Pennsylvania If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea. August 5, 1 5. Social Security Number 6. Sex Age (In vrs. last birthday) Funeral 1 □ M 2 🔁 F Days Hours 59 **Director** 221-40-4493 Usual Residence of Decedent 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shot any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10c. City, Town or Location 10a. State Director 1 Yes 2 M No Maryland Calvert Lusby 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 20657 12595 Catalina Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? 1 ☐ Yes 2 ☐ No 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 Yes 2 Pro Specify: Specify: White If Yes, Give 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Bakery Baker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Dorothy Unknown Walter Gudzelak 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 12595 Catalina Drive, Lusby, MD 20657 David J. Pollin / Spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 03/14/2012 Tullytown, Pennsylvania 4 Donation 5 Other (Specify) Tullytown Cemetery 22. Name and Address of Facility Rausch Funeral Home, P.A. . Signature of Funeral Service Licensee DRO 4405 Broomes Island Road, Port Republic, MD 20676 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ ARKINSON Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) • Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after cleath.
• Funeral Director, After this certificate has been signed by the attending physician and letted filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) 9 | Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 2 No 3 Probably 4 Unknown Division of Vital Records, 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 🗌 Yes 2 🔲 No 1 Yes 2 N 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 1 Yes 2 No ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury work' 1. Natural 5 Pending 1 🗌 Yes Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier completed (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2

To the only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar #310

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HOSPITAL

1150233

PRINCE PREDERICK MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) March 5, 2012 Physician/ 9:40 am Delila R. Perez Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Olney Montgomery Medstar Montgomery Medical Center 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth . Social Security Number 7. Age (In yrs. last birthday) **Funeral** (Month, Day, Year) Country) 220-77-0161 1 □ M 2 🔀 F Director March 25, 2007 MD Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10a. State notified at Director 1 Yes 2 No MD Rockville Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ö er than "natural", or items 23a or the Medical Examiner must be Funeral 20853 USA 13913 Flint Rock Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. þ 1 X Never Married 2 Married 1 Yes If Yes, Give 2 X No 1 🖺 Yes 2□ No Specify:Salvadorean Maryland 21215-0036 Specify:White 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) None n and Mental Hygien 7 is marked other th event, Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည pe 1 Ana E. Aguiluz Helio Edwin Perez other traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health al Important: If item 27 is any injury or other trau 13913 Flint Rock Road, Rockville, MD 20853 Helio Edwin Perez/Father Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date March 8 1 XBurial 2 Cremation 3 Removal from State Gate of Heaven Cemetery Silver Spring, MD 4 Donation 5 Other (Specify) 2012 21. Signature of Funeral Service Licensee Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ Min neumenie Medical resulting in death) Examiner men Sequentially list conditions, if any, isability to infinite cause. Enter Underlying Examine or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury for use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Year 4 Pregnant Pregnant at time of death Yes been signed by the a should be detached 1 ☐ Yes 2 ₹ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? ate has l performed's 1 ☐ Yes 2 ☑No Yes 2 No certificate funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ၉ 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 I DOA Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: after death. Natural injury 5 Pending 1 Yes 2 No Investigation Accident 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) ģ determined 4 Homicide n 24 hours after e Funeral Dire sletely filled in b Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a, Certifier within 24 hou

To the Fune

completely fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d, Date signed (Month, Dav. Year) 29b. Signature and title of certifier 10050410

Registrar

DHMH 17 Rev 06-2011

State

MAR 0 9 2012

32. Registrar's Signaturé

Proce Philip D. Olney

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 03/05/2012 THEODORE WARDSWORTH PRATHER 1437 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Shady Grove Adventist Hospital Rockville Birthplace (State or Foreign MD Country) If Under 1 Year If Under 24 Hrs. **Funeral** Social Security Numbe . Age (In yrs. last birthday) 8. Date of Birth Hours 12/18/1914 577-24-6185 Director 97 Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Director ms 23a or 28a-f s must be notified 1 XYes 2 □ No MD Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 15201 Elkridge Way, 20906 USA ral", or items ? Examiner mus 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 24 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. . 0. Completed by 1 Never Married 2 Married 1 Yes if Yes, Give 21215-0036 1 Yes 2 No Specify: "natural", 3 X Widowed 4 ☐ Divorced Specify: Black Year or Dates event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Men United States Elementary/Seconday (0-12) College (1-4 or 5+) Clerk Government 12th Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Darius Prather Sarah Copeland 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dennis Prather/son 15201 Elkridge Way, #3E, Silver Spring, MD 20906 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place Nat'l Memorial Pk | 03/12/2012 | Laurel, MD 4 Donation 5 Other (Specify) MD Funeral Service Licens 22. Name and Address of Facility Snowden Funeral Home 246 N. Washington St, Rockville, MD 20850 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between myocardial infarction Onset and Death Immediate Cause (Final acute Physician/ disease or condition Medical resulting in death) Due to (or as a consequence f): Examiner arTer -a15 covonani Sequer tially list conditions if any, leading to immediate cause. Enter Underlying Examine pu D Cause (Disease or iinjury that initiated events resulting in death) Last that the death certificate be executed Due to (or as a consequence of): physiciar Physician/Medical Division of Vital Records, P.O. Box 68760 the attending IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death use 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No signed by the atte 5 Other (specify) Month Day Year Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔁 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 No __ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific sompleted filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🔀 No 1 Tyes 1 Inpatient 2 TER/Outpatient 3 IDOA 27 Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes Investigation 6 Could not be 2 🗌 No Accident 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 [Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of 29d. Date signed (Month, Day, Year)

State Registrar

MARCHS,

PRATHER

DOORE

THE

Medical

center Drive,

Fockwillt,

May land 20550

30. Name and address of person who completed cause of death (Item 28a) (Type, Print)

Dooler

MAR 0 9 2012

William 31. Date filed (Month, Day, Year) MD

9901

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ **FRANCIS** J. ROMANO, MARCH 2012 10:10 a M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death 21 Summit Rd. Earleville Cecil If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Funeral 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Days 1 X M 2 🗆 F Months Hours sept 15 1937 Director 208-28-1043 74 Pennsylvania Usual Residence of Decedent show "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits Director 1 ☐ Yes 2X No PA Chester West Chester 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1418 Center St. 19382 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces 2 No 1957 Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 within 72 hours after X Yes 1 ☐ Yes 2X No Specify: White If Yes, Give Year or Dates. -19583 X Widowed 4 Divorced th and Mental Hygiene. 27 is marked other than "natur traumatic event, the Medical I 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) 12 Owner - Operator Dry Cleaning Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame, ျ Francis J. Romano, Sr. Margaret E. Beaver 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kimberly Carpenter (daughter) 21 Summit Rd. Earleville, MD. 21919 other 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) 3/22/12 Paoli, PA. tan Cemetery 21. Signature of Mineral Service 22. Name and Address of Facility Galena Funeral Home of Stephen L. Schaech 118 West Cross St. Galena, MD. 21635 MO0510 Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause Final Leukenna Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): and -tran Due to (or as a consequence of): resulting in death) Last physician Physician/Medical certificate be 68760 use as attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Pregnant at time of death Day Year 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☑ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 X No Hospital Daughter Home Other: မ 1 Yes 1 Inpatient 2 I ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 🛭 Other (Specify 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending injury 2 Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined

Division of Vital Records, al or Attending Physician: The safter death. completed filled in by the funeral director, Hospital

Medical

29a. Certifier

(Check

only one) 29b. Signature and title

MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

certifie

Shahnawaz Khan, M.D. 2533 Augustine Herman Hwy. Chesapeake City, MD.

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

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12

31. Date filed (Month, Day, Yea.

MAR 2 3 2012

Registrar

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death TARCH Anna Catherine Riffle Facility Name (if not institution, give street and number) Town or Location of Death 4c. County of Death HARLES EDICAL ATA Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex If Under 1 8. Date of Birth Min (Month, Day, Year) 70 215-38-4048 1 □ M 2 □XF 07/29/1941 Parkland, MD Usual Residence of Decede 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Charles Charlotte Hall 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14155 Federal Hill Place 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 X Married Yes 2 X No 1 ☐ Yes 2 X No Specify. If Yes, Give Year or Dates White Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Home 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) John C. Gottlied Anna C. Geppert 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1925 Watlington Drive, Charlotte, NC 28270 Anita Tate / Daughter 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) Paul's Lutheran 4 ☐ Donation 5 ☐ Other (Specify) Mechanicsville, MD 03/17/2012 Cemetery 21. Signature of Juneral Sa 22. Name and Address of Facility Brinsfiedl-Echols F.H., P.A. #M00817 30195 Three Notch Rd., Charlotte Hall, MD 20622 cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, or co Approximate Interval Between shock, or heart fallure. List only one cause on each line Immediate Cause (Final Onset and Death disease or condition resulting in death) Due to (or as a consequence of) Parlansons Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Dav Pregnant Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown

Physician/ Medical Examiner

Physician/

Medical

10a, State

MD

Examiner

Funeral

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permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic eve once.

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Director

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Examiner use as the burial-tran for

IF FEMALE

and attending physician Physician/Medical signed by the at d be detached for þ Completed peen rerai Director: After this certificate has filled in by the funeral director, page 23 24 hours after death.

Funeral Director: After this certificate Be ပ Certificate:

Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760

24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy 2 KNO 1 Yes 25. Was case referred to medica examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 🗆 Yes 2 DKN0 1 Manpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 5 Pending iniury 1 Natural Investigation Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 29a. Certifier 🗷 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year)

MO Name and address of person who completed cause of death (Item 23a) (Type, Print)

LAPLATA Md. 20646

State

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Date filed (Month, Day, Year) Registrar

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day 2012 Year March Jane Reardon 8. 1:56 ам Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 5430 Odell Road P.G. Beltsville Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs, last birthday) 8. Date of Birth (Month, Day, Year) Min. 215-62-6090 Director 1 □ M 2 🏻 F 52 Jan. 23, 1960 MD Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Director 1 Yes 2X No MD Beltsville P.G. 10e, Street and Number 10f. Zip Code 10q. Citizen of What Country? Funeral 5430 Odell Road 20705 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc or) þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 72 hours after SpecifWhite 1 ☐ Yes 2 No Specify: "natural", 3 🗆 Widowed 4 🗆 Divorced Completed Year or Dates permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) Manager Grocery 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Arthur W. Wentland, Jr. Martha Ann Gibney 19a. Informant's Name/Relationship (Type, Print)—Husband 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Albert D. Reardon, Jr. 5430 Od<u>ell Road</u>, Beltsville, MD 20705 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State March 13. 1

⊠ Burial 2

☐ Cremation 3

☐ Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Union Cemetery 2012 Burtonsville, MD 21. Signature of Funeral Service Licenses Francis de Collins Funeral Home 500 University Blvd. W., Silver Inc. Spring, MD 20901 Part 1. Enter the disease, or complications that caushock, or heart failure. List only one cause on each life 23a Part 1 the death. Do not enter the most of dying, such as cardiac or respiratory arrest, #al Between an Immediate Cause (Final Phynician disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events Due to for as a consequence of Exami Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last physician s the buria Physician/Medical Division of Vital Records, P.O. Box 68760 use as attending properties as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy Dav Year 5 Other (specify) Pregnant at time of death ed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? this certificate has autopsy performed? Yes 2 No 1 Yes 2 No æ 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 2 No မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: After 1 Natural (Month, Day, Year) 5 Pending injury 1 Yes 2 No Accident Investigation M To the Funeral Director: completely filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 🕰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b Signature a signed (Month, Day, Year) 20/2 り 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6934 IATION W. WELNITT 31. Date filed (Month, Day, Year) State **MAR 09 201** Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / D	epartment of Heal	th and Mental Hy	giene	
				Certificate of Deat		Reg. No. 20 2	0921
T	Physicia	ın/	1. Decedent's Name (First, Middle, Last)		2. Date of De Month	Day Year	3. Time of Death
Marie	Medic Examin		Helen Louise Reidy 4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Locat	March	3 2012 4c. County of Deat	3:25 P ^M
أميووا			Bedford Court Health Center	Silver Sp		Montgome	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birth	day) If Under 1 Year If Under 1 Year Months Days Hou	nder 24 Hrs. 8, Date of Bir urs Min. <i>(Month, D</i> a		hplace (State or Foreign intry)
	Director		Usual Residence of Decedent 1 □ M 2 🛣 F 98	rs.	April 2	24 1913 Penr	sylvania
	rland f shov	to:	10a. State 10b. County 10c. City, Town	or Location			10d. Inside City Limits
	Many 28a-	Director		ver Spring			1 Yes 2X No
	ith the	ral	10e. Street and Number	10f. Zip Code		10g. Citizen of What Co	
	eath w	Funeral	3701 International Drive, Apt.161 11. Marital Status 12. Was Decedent Ever in U.S.	2090 13. Was Decedent of Hispanic	Origin? (Specify Yes or No-	14. Race - Amer	
36	fter de	by	1 Never Married 2 Married Armed Forces? 1 Yes 2 X No If Yes, Give	If Yes, specify Cuban, Mex 1 ☐ Yes 2 【X No Spe		Black, White	white
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212	withir giene ier tha		Elementary/Secondary (0-12) College (1-4 or 5+)	Nurse		Nursin	g
pue	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene, item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	To Be	17. Father's Name (First, Middle, Last)		Mother's Name (First, Middle,		
IZ,	ould be mark maric		Charles Henry McMullen 19a. Informant's Name/Relationship (Type, Print) 19h.	Mailing Address (Street and Nu	Anna May Vosw		Ondah
\mathbf{N}	d 2 sh alth ar 27 is r trau		1	Avondale Drive			Code
Baltimore, Maryland 21215-0036			20a. Method of Disposition 20b. Place of	Disposition (Name of c, crematory or other place)	March 6,	20c. Location - City or	Town, State
ţi	Page Iment o tant If jury or		1 - Buildi 2 11 Cremation 5 - Herrioval nom Ctate	olitan Crem.	2012	Alexandria	, VA
Bal	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Licensee . MO1202		acility DeVol Fur		MD 20077
			23a. Part 1. Enter the disease, or complications that caused the death. Do not	10 E. Deer Pa			Approximate
. m	Ph_sician		shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Atherosclerotic	Can'ld ana - au 1	Dd		Interval Between Onset and Death
	Medical Examiner		disease or condition resulting in death) Atherosclerotic Due to (or as a consequence of		il Disease		Years
	LXairiiiici	Je.	Sequentially list conditions, b.				
	pa	Examiner	if any, leading to immediate Due to (or as a consequence of cause, Enter United Jying Cause (Disease or injury):			
	re be executed sysician and he burial-	Еха	that initiated events resulting in death) Last C. Due to (or as a consequence of):			
00	is that the death certificate be executed greed by the attending physician and be detached for use as the burial.	dical	d				
	artifica ding ph	<u>e</u>	IF FEMALE: 23b. We decoded program 23c. If yes, outcome of pregnancy				
Box 687	ath ce attend for us	cian	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 4 Pregnant at time of death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of deli Month	very Day Year
. B	the de	hysi	9 Unknown				
P.O.	The law requires that the death certifica ate has been signed by the attending plage 2 should be detached for use as t	by	Part II. Other significant conditions contributing to death but not resulting in Severe Systolic Dysfunction	the underlying cause given in F		obacco use contribute to	
rds	equire reen s hould	eted				Yes 2 X No 3 □ Pr	
eco	hysician: The law r nis certificate has b Il director, page 2 s	Completed	Hypertension, Congestive Heart Fai Failure To Thrive	lure	24a. Was autor perfo		opsy findings available ompletion of cause of
E B	an: The tifficate tor, pa	Be Co	25. Was case referred to medical	26. Place of	Death (Check only one)	2 X No 1 Yes	2 No
Vit	nysicia lis cer direc	To B	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Out	Otherm	☑ Nursing Home 5 ☐ Resid	dence 6 Other (Speci	fy)
l of	ing Pt		27. Manner of Death 1 X Natural 5 Pending 28a. Date of injury (Month, Day, Year) inj	me of 28c. Injury at work?	28d. Describe h	ow injury occurred	
sior	uttend death ctor; / y the I	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be	M 1 ☐ Yes 2		Street and Number or Run	al Pouto Number
Division of Vital Records,	al or / s after al Dire ed in b		4 Homicide determined building, etc. (Specify)	.,,,,	City or Tow		a riodio riomod,
_	To the Hospital or Attending Physician: whithin 24 hours after death. To the Funeral Director, After this certific completely filled in by the funeral director,	Medical	29a. Certifier 1 X Certifying Physician: To the best of my knowledge, d (Check 2 Medical Examiner: On the basis of examination and/or				
	ithin 2.	Me	only one) 3		e, date and place, and due to t		stated.
	5		1. Junamon	D53367			5, 2012
	F		30. Name and address of person who completed cause of death (Item 23a) (Ty			nar ch	-, -012
			Shyamsundar Rajan, M.D., 9801 Geor		e. 117, Silve	r Spring, MI	20902
	Star Registra		31. Date filed (Month, Day, Year) NAR 0 9 2012 32. Registrar's Signature	wed.			
		-		1.			

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ March Day 2012^{ear} 8:30P. Earl J. Robinson, Sr. Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Prince George's Renaissance Gardens at Riderwood Village Silver Spring If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 🟋 M 2 🗆 F Months Days Hours 578-01-6123 103 NOV. 1299. 1908 VifgThia Director Usual Residence of Decedent be filed within (2 11000).
iental Hygiene.
arked other than "natural", or items 23a or 28a-f snow
arked other than "natural", or items 23a or 28a-f snow
arkic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Prince George's Maryland Greenbelt 1 ☐ Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 122 Rosewood Drive 20770 United States Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 Married ğ Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 No Specify: 3 ♥ Widowed 4 □ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Mechanic Aircraft 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental I is marked o ျှ Inzi Robinson Mary Dodd 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Helen Foster -daughter 1 and 2 s of Health item 27 122 Rosewood Drive Greenbelt, Maryland 20770 20a. Method of Disposition
1 🔀 Burial 2 🗆 Cremation 3 🗔 Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any injury or o cemetery, crematory or other place)
Brownsville Cemetery 3/10/2012 Brownsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Bonard Av. Borgwardt Funeral Home, PA Donald 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Betweer shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) 10 years Physician/ Squamous Cell Carcinoma Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Linter Underlying Due to (or as a consequence of): e burial-transit requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the buria Physician/Medical IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) Live Birth 2 - Fetal death in the past 12 months? Month Pregnant at time of death 1 Yes 2 No 9 Unknown the P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23e. Did tobacco use contribute to the cause of death? Chronic Obstructive Pulmonary Disease Division of Vital Records, cate has been signated by page 2 should by Completed 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown To the Hospital or Attending Physician: The law requirin 24 hours after death.

To the Funeral Director. After this certificate has been completed filled in by the funeral director. 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy perform 1 ☐ Yes 2 💢 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner?
1 Yes 2 No Other: 4 X Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certific 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year,

MAR 0 9 2012

DHMH 17 Rev 7/2009

Eileen Gemmell, CRNP 3160 Gracefield Road Silver Spring, Maryland 20904

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year Schneider I George 11:47PM MARCH 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death GENESIS WALDORF CENTER CHARLES WALDORF 9. Birthplace (State or Foreign Country) Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. 8. Date of Birth 5. Social Security Number Months Days Hours 1 🙀 M 2 🗆 F 1-30-1960 217-76-5994 52 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City. Town or Location 1 🗌 Yes 2 🔀 No CHARLES WHITE PLAINS MD. 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 9315 BILLINGSLEY ROAD 20695 U.S.A. . Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Was Decedent Ever in U.S 11. Marital Status Armed Forces Black, White, etc. Yes 2 X No 1 Never Married 2 Married 1 ☐ Yes 2 √ No Specify. Specify.WHITE If Yes, Give 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) SELF EMPLOYED AUTO MECHANIC 11th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) GRACE ALINE HAMILTON GEORGE A. SCHNEIDER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) GEORGE SCHNEIDER-FATHER 9315 BILLINGSLEY RD. WHITE PLAINS, MD. 20695 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition MEM.GARDENS 3-20-12 WALDORF, MD. 2. Name and Address of Facility RAYMOND FUNERAL SERVICE, P.A. RAYMOND MARYLAND 20646 Signature of Funeral Service Licensee M00479 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final 88 hosis disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions. it any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death g Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause givan in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? Dendence 24a Was an autopsy 2 No 1 Yes 26. Place of Death (Check only one) Other: 4 Nursing Home 5 - Residence 6 - Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 DOA

Examine attending physician and for use as the burial-transit by Physician/Medical signed by the a Id be detached f Completed After this certificate has been funeral director, page 2 should Be မှ Certificate: within 24 hours after deatl completed filled in by the

To the Hospital or Attending Physician: The law requires that the death certificate be executed

P.O. Box 68760

Division of Vital Records.

Physician/

Medical

Examiner

Funeral

Director

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Physician/

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Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.

Baltimore, Maryland 21215-0036

25. Was case referred to medical examiner? 1 Tyes 27. Manner of Death

Natural

2 Acciden
3 Suicide Accident

29a. Certifier

5 Pending Investigation 6 Could not be

28a. Date of injury (Month, Day, Year)

28b. Time of 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at

1 Yes 2 No

28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

NAR 23

29c. License number D71199 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) by Blud, SteB, Glen Burn @, MD, 21061

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Month Dav **Physician** 7:55 a^M 15, 2012 March Ira H. Snyder /Medical 4c. County of Oeath 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Washington Hagerstown Golden Living Center Honghs Days Hours Min. (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days 1 XM 2 ☐ F 11/28/1936 Maryland 75 Director 212-38-9274 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 2 should be filed within 72 hours after death with the Marylan and Mental Hygiene.
I e marked other than "naturat", or iteme 23a or 28a-1 show sumatic evert, I in a Wickel Expirite most tended to the most sumatic evert, I in a Wickel Expirite most tended to the sumatic evert. 1 ☐ Yes 2 X No Director MD Washington Hancock 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21750 14406 Bain Road Funeral 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0036 White 2 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Agriculture Laborer Unknown other traumatic event, 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be nent of Heelth and Mental Blanche Mann Guy Snyder 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permil. Pages 1 and 2 s
Department of Heelth ar
Important: If Item 27 le
any injury or other trau P.O.Box 172 Smithsburg, MD Bonnie Winders/Guardian 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Stonebridge Cemetery 03/15/2012 Hancock, MD 21. Signature of Funeral Service Licen-22. Name and Address of Facility 141 West Main Street M00260 Grove Funeral Home.P.A. Hancock, MD 21750-0368 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval 8etween Onset and Death Immediate Cause (Final disease or condition resulting in death) arten MINL Coronarry **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician: The law requires thet the death certificate be executed physicien and the burial-transit Due to (or as a consequence of) Box 68760, Physician/Medical ettending ph IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) P.0. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No certificete has b irector, page 2 sl 2 No 1 ☐ Yes After this certification, funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 🗖 No 2 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A al Director: 2 Accident investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D28261 3-16-12 30. Name and address of person who completed dause of death (Item 23a) (Type, Print) 368 mill strut Hagestern 1910 21740 SHARI 32. Registrary Signature 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Physician /Medical Examiner 4a. Facility Nam	msport Nur ty Number 6. S	a Jane SAN e street and number) sing Home	NER		4b. City. Town, or	Location of Death	2. Date of De Month March	10, Day 2	012 Year	3. Time of Death 5:30a.M
/Medical Examiner 4a. Facility Nam Willia Funeral Director 176-40- Usual Residence	msport Nur ty Number 6. S	e street and number)	NER		4b. City. Town, or	Location of Death	March	-		
Willia Funeral Director Willia 5. Social Securi 176-40-	msport Nur ty Number 6. S	sing Home			4b. City, Town, or	Location of Death				
Funeral Director 5. Social Securi 176–40–	ty Number 6. 5		4a. Lacinty Ivania (in not institution, give blood and variable)				wn, or Location of Death iamsport 4c. County o			
Director 176-40-	3487	Sex 7. Age	(In yrs. last I	birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Bi	rth	9. Birth	place (State or Foreign intry)
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Pennsy1 10e. Street and	10b. County		10c. City, To	own or Loc	ation					10d. Inside City Limits
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					10f. Zip Code			10g. Citiz	en of What Cou	untry?
121 Woo	dland Road				156				J.S.A.	
d within 72 hours after dea within 72 hours	us Married 2 Married ed 4 Divorced	12. Was Decedent E Armed Forces? 1 Tyes 2 No If Yes, Give Year or Dates:			Vas Decedent of Hi Yes, specify Cuba □Yes 2 X No	spanic Origin? (S) n, Mexican, Puerto Specify:	pecify Yes or N p Rican, etc.)		4. Race - Amer Black, White Specify: wh	, etc.
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Doestmit. Pages 1 a Doestmit. Pages 1 a Doestment of Hee	2 ☐ Cremation 3 ☐ ion 5 ☐ Other (Speci	f(y)	Westn Memor	riai			1 2012	Green	nsburg,	Pennsylvan
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Physician /Medical Examiner Personal pure properties of the prope	ndition ath)	b. Due to (or as Dysp) Due to (or as	HAGI a consequent STAGI	ce of): A ce of):	enile D	PEMENT	A			3 WEBES
d death oertification of the control	edent pregnant st 12 months? 2 □ No	23c. If yes, outcome 1 Live birth 4 Pregnant a 9 Unknown	2 Fetal de	ath 3	☐ Ectopic pregnanc	y			23d. Date of de Month	livery Day Ye ar
	ignificant conditions	contributing to death b	ut not resultir	ng in the u	nderlying cause giv	en in Part 1.				o the cause of death?
The lay atte has page 2	referred to medical	le "				26. Place of De	pe 1 □ Yes	topsy rformed?	prior to death?	utopsy findings available completion of cause of 2 □No
> .20 D		Hospital: 1 ☐ Inpatie	ent 2 EF	R/Outpatie	nt 3 DOA	or:			6 ☐ Other (Spe	ecify)
After this After this funeral di Matura di Mat		28a. Date of Inju (Month, Da		Bb. Time o Injury	Wor		28d. Describ	e how injur	y occurred	
E SESSE OF STACCION	The control of the co								Street and Number or Rural Route Number, wn, State)	
To the Hospital or Atte Within 24 hours after de To the Funeral Direct To the Funeral Direct Completely filled in by the Cheek or one) 3	1 Certifying I	Physiclan: To the best aminer: On the basis of and manner st	of examination	edge, deat n and/or in	th occurred at the t nvestigation, in my	ime, date and plac opinion, death occ	e, and due to t curred at the tim	he cause(s) and manner a d place, and du	is stated. e to the cause(s)
29b. Signatur	and title of certifier				29c. Licen	se number		29d. Da	te signed (Mon	th, Day, Year)
	DE. HOU	JE			D33	700		MA	PCH 10	2012
1	20 0 1 100									
		o completed cause of o	death (Item 2	3a) (Type,	Print) ST, W(1	LIAMS	ORT.	MD	717	75

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2012 Year Month Day Judy Massey Strock 8 March 11:30 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Shady Grove Adventist Hospital Montgomery County Rockville Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday)
68 yrs. 8. Date of Birth **Funeral** March Day 1 M 2 XF 217-42-9215 Mary Land **~**1942 Director Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits notified at Funeral Director 28a-f Maryland | Montgomery County Poolesville 1 X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be items 23a 19145 Dowden Circle 20837 U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, of Health and Mental Hygiene.
item 27 is marked other than "natural", or iter
other traumatic event, the Medical Examiner. Black, White, etc. 1 Yes 2 X No If Yes, Give Year or Dates. Completed by 1 ☐ Never Married 2 🎇 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify: White 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Personal Residence Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Paul C. Massey Margaret Kennedy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau Richard A. Strock-husband 19145 Dowden Circle Poolesville, MD 20837 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Smithsburg Crematory 3-10-2012 4 ☐ Donation '5 ☐ Other (Specify) Smithsburg, MD 21. Signature of Funeral Service License 22. Name and Address of Facility Douglas A. Fiery Funeral Home Eastern Blvd. North Hagerstown, MD 21742 Sn 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Preumonio Physician/ disease or condition weeks Medical resulting in death) Due to (or as a consequence of Examiner Sepsis 2 weeks Sequentially list conditions Examiner if any, leading to immediate Due to (or as a consequence of) Cirrhosis To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or linjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown 1 Live Birth
4 Pregnant
9 Unknown Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: မ 1 2 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d, Describe how injury occurred Natural 5 Pending injury 1 ☐ Yes 2 ☐ No Accident
Control
Contr Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check 29b. Signature and title of certifier 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rockville MD 20150 9901 Murra medical MD Michael 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Physician/ STAUGA ITIS 2 - 55PM ANTOINETTE CAROLINE 2:12 Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** Howard County General Hospital Columbia Howard If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) . Age (In vrs. last birthday) **Funeral** 093-07-0554
Usual Residence of Decedent Director 1 M 2 XF June 10, 1917 Washington 94 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once. 10d, Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 X Yes 2 No Maryland Howard Jessup 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 20794 9950 Guilford Road, Apt. 107 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11 Marital Status Armed Forces?
1 ☐ Yes 2 🗶 No þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. If Yes, Give 3 X Widowed 4 ☐ Divorced White Completed Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Own Home Home Maker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Antoinette Bernabic Joseph A. Marin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 Erasmus Street Lake Oswego, OR 97035 Peter Staugaitis/ Son 20a. Method of Disposition
1 □ Burial 2 ☑ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 3/7/2012 Glen Burnie, MD 4 Donation 5 Other (Specify) Atla<u>ntic Crematory</u> 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Fleck Funeral Home 7601 Sandy Spring Road Laurel, MD 20707 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Phy i ian/ EW DAY disease or condition resulting in death) Medical Examiner FEW DAY Sequentially list conditions, if any, leading to immediate cause Enter Und Hying Cause (Disease or injury Examine Due to (or as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy5 Other (specify) ____ Month Day Year Pregnant at time of death 1 Yes 2 g g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 1 N Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident work? 1 ☐ Yes 2 ☐ No iniury 5 Pending within 24 hours after death.

To the Funeral Director: All completely filled in by the fu Investigation 6 Could not be Suicide 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical (Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

only one)

29b. Signature and title of certifie

HICKINY RIDGE RD 32. Registrar's Signature

Registrar

Doc62634

29d. Date signed (Month, Day, Year) MAR 03, 20/2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) FEBRUARY 29 2012 Physician/ 7:20A LUTHER WILTON SMITH Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Examiner TALBOT 29416 STONEY RIDGE CIRCLE EASTON 8. Date of Birth 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) **Funeral** (Month, Day, Days Hours 1**X**☐ M 2 ☐ F Months MARYLAND Ĩ 925 86 Director 218-16-9525 Usual Residence of Decedent 10d. Inside City Limits "natural", or items 23a or 28a-f show edical Examiner must be notified at 10c. City, Town or Location 10a. State 10b. County filed within 72 hours after death with the Maryland Director 1 Yes 2 No TALBOT EASTON MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Numbe USA 29416 STONEY RIDGE CIRCLE 21601 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces? Black, White, etc. 1 Never Married 2 X Married 1 XYes 2 No þ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Specify: WHITE Completed 3 Widowed 4 Divorced Year or Dates other traumatic event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry (Give kind of work done of life, DO NOT use retired) during most of working n arked other than Elementary/Seconday (0-12) College (1-4 or 5+) PRINTING COMPANY 8 -0-OWNER/OPERATOR permit Page 1 and 2 should 1 e fled Department of Health and Mental Hyg Important: If item 27 is marked any injury or other *** Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) RUTH EDWARDS FLOYD ROY SMITH 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 7837 OCEAN GATEWAY, EASTON, MD 21601 LARRY W. SMITH, SON 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 🕅 Burial 2 🗌 Cremation 3 🗆 Removal from State EASTON, MARYLAND WOODLAWN MEMORIAL PARK 3/10/2012 4 Donation 5 Other (Specify) FELLOWS, HELFENBEIN & NEWNAM FUNERAL 200 SOUTH HARRISON STREET EASTON, MD Signature of Funeral Service Licensee HOME 21601 R JOHN MERCE 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Due to (or as a consequence of) Physician 6275 disease or condition Medical resulting in death) ratery infection Examiner Sequentially list conditions, Due to jor as a consequence of: Examine trany, leading to immediate cause. Enter Underlying Cause (Disease or linjury CAME LA EXIV been signed by the attending physician and should be detached for use as the burial-trans that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical 7 Hospital or Attending Physician: The law requires that the death certificate be Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Live Birth 2 Fetal death in the past 12 months?
1 Yes 2 No Month 5 Other (specify) Pregnant at time of death 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of 24a Was an autopsy page 2 death? Yes 2 No 1 Yes 2 No this certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Division of Vital director, Be Other: 4 Nursing Home 2 No 5 Residence 6 Other (Specify) 1 Yes ER/Outpatient 3 DOA မှ 1 Inpatient 2 I funeral 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after death. Funeral Director: A Investigation completed filled in by the 6 Could not be 28f. Location (Street and Number or Rural Route Number, 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of DA5750 no completed cause of death (Item 23a) (Type, Print) 30. Name and address

DS 15+1 VA State

MAR 0 5 2012

ROBERT B. SANCHEZ, MD 508 IDLEWILD AVENUE, EASTON, MD 32. Registrar's Signature

Registrar

21601

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Medical □2012 11:00 A M March 7. Bernard SCHWAB 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Silver Spring Necitas Assisted Living If Under 1 Year If Under 24 Hrs. 8. Date of Birth g. Birthplace (State or Foreign 7. Age (In yrs. last birthday **Funeral** 019-20-2490 1 **X** M 2 □ F Months Davs Hours Dec. 26, Year 926 Massachusetts **Director** 85 Usual Residence of Decedent 10c. City, Town or Location 28a-f shov 10b. County 10d. Inside City Limits items 23a or 28a-1 snooner must be notified at with the Maryland Director Silver Spring Maryland Montgomery 1 🗆 Yes 2 🏋 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 20901 709 McCeney Avenue Page 1 and 2 should be filed within 72 hours after death 1 nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian. 11. Marital Status Examiner Armed Forces?

1 X Yes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 Married ģ white Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 Widowed 4 Divorced Completed Year or Dates. WW II the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Ith and Mental Hygiene. 27 is marked other than "r r traumatic event, the Med U.S. Department of College (1-4 or 5+) Elementary/Seconday (0-12) Agriculture 5+ Microbiologist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Rebecca Kreplick David Schwab 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
709 McCeney Avenue, Silver Spring, MD 20901 Susan Marder, Daughter Department of Health Important: If item 27 any injury or other to once. 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place Mt. Lebanon Cemetery 03/09/12 Adelphi, MD 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Luneral Service Funeral Service Licenses 21. Signatur 5517 Vine Street, Alexandria, VA 23a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician/ disease or condition Medical resulting in death) **Examiner** Sequentiary list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine • the Hospital or Attending Physician: The law requires that the death certificate be executed thin 24 hours after death.
• the Funeral Director. After this certificate has been signed by the attending physician and mpleted filled in by the funeral director, page 2 should be detached for use as the burial Haratt Due to (or as a consequence of): resulting in death) Last Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IE FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month 5 Other (specify) Day Year Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? assisted 2 🖸 No Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 1 Natural 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours aft

To the Funeral Di

completed filled in Medical 29a. Certifier

Registrar

DHMH 17 Rev 7/2009

State

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(Check

29b. Signature a

only one

d title of certifier

30. Name and address of person who comple

MAR 09

31. Date filed (Month, Day, Year)

1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

DIEFOTAL DE.

LINTHICHM

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra AMEND#7perFH, 3/14/12; BMW, MoCo Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month ^{Day} 2012 4:45 AM March 6, Benjamin L. Spaulding Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death
Silver Spring 4c. County of Death

Montgomery Examiner Sunrise of Silver Spring Age (In yrs. last birthday) 8. Date of Birth Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Months Days 1 X M 2 🗆 F oct. 12. 579-01-4282 South Carolina Director Usual Residence of Deceden 28a-f shov 10a. State D C 10b. County 10d. Inside City Limits 10c. City, Town or Location with the Maryland must be notified at Director N/A Washington 1 X Yes 2 No 10f. Zip Code 5 10e. Street and Numbe 10g. Citizen of What Country? United States 20011 Completed by Funeral 23a 4131 New Hampshire Avenue, NW Page 1 and 2 should be filed within 72 hours after death a ment of Health and Mental Hygiene.
sint. If item 27 is marked other than "natural", or items uny or other traumatic event, the Medical Examiner muy or other traumatic event, the Medical Examiner muy or other traumatic event, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married A frican Baltimore, Maryland 21215-0036 1 ☐ Yes 2 Ho Specify: A merican 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed, College (1-4 **4yrs** Federal Government Elementary/Seconday (0-12) Claims Specialist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Benjamin T. Spaulding ၉ Laura Dobey 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 0011 4131 New Hampshire Avenue, NW, Washington DC 19a. Informant's Name/Relationship (Type, Print) William Thompson / nephew 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any injury or o Burial 2 Cremation 3 Removal from State 3/12/2012 Suitland, Maryland Lincoln Mem. Cemetery 4 Donation 5 Other (Specify) McGuire Funeral Service, 21. Signature of Funeral Service Licenses 22. Name and Address of Facility drolle Tho 7400 Georgia Avenue, NW, Washington DC 20012 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ Cardiopulmonary disease or condition Medical resulting in death) Due to (or as a consequence of **Examiner** Atherosclerotic Heart Disease Sequentially list conditions. Examine Due to for as a consequence of cause. Enter Underlying Hypertension the burial-transf Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FFMALE yes, outcome of pregnancy
Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) Pregnant at time of death ed by the detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed by be det þ Alzheimer's Disease 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy has page 2 perform 1 Yes 2 No 1 Yes 2XXN Be 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, examiner? 2 🔀 No Other: 4 Nursing Home 5 Residence 6 Other Specify မ 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: X Natural 5 Pending work? 1 Yes 2 No Accident Investigation within 24 hours after deatl

To the Funeral Director:
completed filled in by the 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Ecritifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one

State Registrar 29b. Signature and title

Michael D. Cannaday,

M.D., 106 Irving St., NW, Washington DC 31. Date filed (Month, Day, Year) 32. Registrar's Signature MAR 0 9 2012

30. Name and address of person who completed cause of death (tem 23a) (Type, Print)

29c. License numbe M D19730 29d. Date signed (Month, Day, Year)

Suite #305

March 6, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 09221 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day 1:25am Medical March 05 2012 4a. Facility Name (if not institution, give street and number, Examiner 4b. City, Town, or Location of Death 4c. County of Death Pine View Nursing Home Clinton rince George Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 🗆 M 2 🗶 F Days Hours 0372571930 Mississippi **Director** Yrs 579-34-5010 81 Usual Residence of Decedent 28a-f shov 10a. State 10b. County with the Maryland 10c. City, Town or Location the Medical Examiner must be notified at 10d. Inside City Limits Director Md Montgomery Silver Spring Yes 2 No ò 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funera 531 Randolph Road # 244A 20904 USA items · death v 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Force Black, White, etc. ò þ 1 Never Married 2 Married 1 Yes 2 X No within 72 hours after Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify. "natural" 3 Midowed 4 Divorced SpecifyBlack Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) uth and Mental Hygiene. 27 is marked other than "I r traumatic event, the Med College (1-4 or 5+) Elementary/Seconday (0-12) Contractor Federal Government 12th Be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) rmit, Page 1 and 2 should be file Department of Health and Mental Important: If item 27 is marked of any Injury or other traumatic eve ပ္ James Carey Maggie Phillips 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4208 Payne Dr Fort Washington, Md 20744 Sharon Stewart Daughter timore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Fort Lincoln Date 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State 03/10/12 Brentwood, Md 4 ☐ Donation 5 ☐ Other (Specify) 21. Signaturo Lineral Service License G PHILIP ODS RINALDI FUNERAL SERVICE, P.A. Columbia Blvd.Silver Spring, Md20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of ding, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in ach line. Immediate Cause (Final Onset and Death Pnysician/ disease or condition Medical resulting in death) Due to (c onsequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate Due to (or as a consequence of): ital or Attending Physician: The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of): the burial attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) Day Year 2 No as been signed by the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an certificate has page performed? Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical funeral director. Be 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 ☑ No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury death. 2 Accident 1 ☐ Yes 2 ☐ No after death Investigation the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) yompleted filled in by 4 Homicide determined within 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) Signature and title of cert 29d. Date signed (Month, Day, Year) 3

State

Registrar

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Day

MAR 09

31. Date filed (Month,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1	For State Registrar	State of Maryland		rtment of H			ene 1. No. 2012	09222
			Decedent's Name (First, Middle, Last)					2. Date of Death	Day Year	3. Time of Death
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	edica imine		4a. Facility Name (If not institution, give		upo c	4b. City, Town, or	Location of Death		4c. County of Dea	
LAG			Golden Living	Center		Hagers	town		Washing	gton
Fune	ral		5. Social Security Number 6. Sec	7. Age (In yrs. I	ast birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,)	(ear) 9. Bir	thplace (State or Foreign ountry)
Direct			219-34-7381	[™] ² √ F 93	Yrs.	Months Days	HOUIS WIII.	7/14/19	18 WV	
р.		-	Usual Residence of Decedent	140.00	. Town or Lo					10d. Inside City Limits
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or 2	9		10e. Street and Number			10f. Zip Code			g. Citizen of What Co	ountry?
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be filed within 72 hours after death with the Maryland hall Hyglene. The doubt then natural, or lieme 23a or 28a-1 ehow worth the Maryland serving the profiled and the serving the s		Completed by Funeral Director	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	S. 13. \	Was Decedent of Hi f Yes, specify Cuba	spanic Origin? (Si n, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - Ame Black, Whi	
s afte		<u> </u>	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☐ No If Yes, Give A Year or Dates:		1□Yes 2⊠No	Specify:		Specify:	h 3 L m
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200	Ě		17. Father's Name (First, Middle, Last)		mana	igei	18. Mother's Nan	ne (First, Middle, Ma		
nd 2 should be file Ith and Mental Hy 27 is marked oth		Be	Emory Frankli	n Thompson			Emma	Melissa		
should be nd Menta marked		၉	Emory Frankli 19a. Informant's Name/Relationship (T)			ng Address (Street a			City or Town, State,	Zip Code)
d 2 s th an			Jeff Bishop	(Grandson)						
		18.	20a. Method of Disposition	20b. P	lace of Dispo	sition (Name of		Actual Control of the	0c. Location - City or	
m 0 - 1	ö		1 M Burial 2 ☐ Cremation 3 ☐ F	removal from State		natory or other plac		1/2012 N	(cConnel	lsburg,Pa.
permit. Page Department of Important: If	로 [1	4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licens			emetery 2. Name and Addres		1/2012 F.	icconner.	isburg/iu.
Dermit. Pages 1 at Department of Hee Important: If item	D C C		23a. Part 1. Enter the disease, or comp	M. L. mare	2 0-		HOT	ward L.	Sipes F	uneralHome
Wedicarian and strength of the personal strength of the streng	ner	cai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence) Due to (or as a consequence) Due to (or as a consequence)	uance of):					
the death certification by the attending principle of the attending princip	for use as t	Physician/Medio	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d 9 □ Unknown	I death 3[⊒Ectopic pregnancy □ Other (specify)			olivery Day Year	
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sicien: The law requires to certificate has been signs		Completed		1				24a. Was an	24b. Were a	autopsy findings available completion of cause of
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l or Attending after death. Director: After	in by th	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, st y)	reet, factory, office		28f. Location (Str City or Town		Rural Route Number,
Hospita 24 hours Funeral	etely filled	Medical Co		ysician: To the best of my kno liner: On the basis of examina and manner stated.						
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			30. Name and address of person who o	completed cause of death /Ite	n 23a) (Tune		16 JA.			2/7-41
11-8	3		55. Hame and address of person with t	hand MI	, (1ype	SOC N	ודו בת זדן	Aug W	act nave	21742 n My
14	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Signa	ature		162	1100	3	
Re	gistr		MAR 142	U12 Armond	1. 1	mal				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State of Market State of Market Registrar 19b, FH, 3/5/12, rls Amended# Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Raymond G. Teeling 2:30 March Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death The Pines Talbot Genesis ElderCare -Easton Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) 11.Y. **1X** M 2 □ F Days 084-18-1680 Months Hours Min. 11 Mor 27 Day 925 86 **Director** Usual Residence of Decedent 28a-f shov 10b. County 10c. City, Town or Location 10d. Inside City Limits Director be notified Md. Talbot St. Michaels 1 X Yes 2 No 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? Funeral 203 Mulberry Street 21663 U.S.A. filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

Yes 2 No Air Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 X Married mond Telling Maryland 21215-0036 If Yes Give 1 ☐ Yes 2 X No Specify. White Specify: 3 Widowed 4 Divorced Completed Year or Dates. Force 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 12 College (1-4 or 5+) Industrial Sales Equipment Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental Finportant: If item 27 is marked o any injuy or other traumatic eve once. မ Teeling George Helen Plunkett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jacqueline Teeling / Wife P.O. Box 29 St. Michaels MD 21663 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Crem. of Delmarva 03-05-2012 Delmar, 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee harleynt Ostrowski Funeral Home P.A M. OstRowsk: P.O. Box 518 St. Michaels, Md. 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on eagh line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical **Examiner** years Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury attending physician and for use as the bunal-tran that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) Month Day Year signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 ☐ No 2 N Division of Vital filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 1 Yes Certificate: To 1 Inpatient 2 ER/Outpatient 3 IDOA Nursing Home 5 \square Residence 6 \square Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work s after death. 2 No Investigation Could not be Accident Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RS 4+1 VA

Raymond

State Registrar DUTCHMANS

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gistrar's Signature

			For State Registrar	lease		f Marylan			t of H	lealth		•		e	0.12	09221
	Physicia Medic		1. Decedent's Name (First, I	e I	aylor							2. Date of De Month March		Day 2012	Year	3. Time of Death 11:00 p. m
6	Examin		4a. Facility Name (if not insti					4b. City, Town, or Location of Death							y of Death	
18	Funeral		Hospice Hou 5. Social Security Number	se of		ary's 7. Age (In yrs. Ia	ast birthday)		1 Year	If Under		8. Date of Bir	th			place (State or Foreign
Ш	Director		081-36-9897		□ м 2 🛣 ғ	66	Yrs.	Months	Days	Hours	Min.	(Month, Da			New	- //
	land show d at	ğ	Usual Residence of Deced 10a. State 10b. C			10c. City, Town or Location				L	10/2//	194.)		10d. Inside City Limits	
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	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho amy injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral Director	10e. Street and Number			_	•	10f. Zip					_		What Cou	
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ပ္	er dea or ite miner	y Fu	11. Marital Status1 ☐ Never Married 2 ☐	Married	Armed Fo	rces? 2 X No						ecify Yes or No- Rican, etc.)			ck, White,	
Maryland 21215-0036	ural", ural", Il Exal	Completed by	3 Widowed 4 X Div		If Yes, Giv Year or Da	е		! ☐ Yes :	2 [X] No	Specify:	:			Specify	" <u>Bla</u>	ck
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092	eath certificate be ex attending physician for use as the buria	edical														
. Box 6876	Attending Physician: The law requires that the death certificate or death. ector: After this certificate has been signed by the attending physic by the funeral director, page 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnar in the past 12 months? 1 Yes 2 No 9 Unknown	t	1 Live	come of pregna Birth 2 Feta nant at time of c nown	al death 3	Ectopic p Other (sp		у					ate of deliv	very Day Year
ls, P.O.	requires that the des been signed by the s should be detached	d by Pl	Part II. Other significant co	nditions c	ontributing to d	eath but not res	ulting in the u	inderlying o	cause giv	en in Part	I.	23e. Did 1	-			he cause of death?
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	To the Hospital or A within 24 hours after To the Funeral Direct completely filled in b	Medical	(Check	ical Exam	iner: On the bas	est of my knowless of examination To the best of n	and/or inves	tigation, in r , death occ	my opinic urred at th	n, death o ne time, da	ccurred a	t the time, date	and place the cau	ce, and du se(s) and	ue to the ca manner as	use(s) and manner stated.
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V	Sta	e	Jennifer Sch 31. Date filed (Month, Day,	ear)	32	egistrar's Signar										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 3 Physician/ aM OHN RUSSELL 1055 VERROYCKE Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** KNIVE ANNAPOLIS ARUNDE MEDICAL CENTER ARUNDEL 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Social Security Number **Funeral** Days Hours 577-22-5001 1 **X** M 2 □ F **Director** 98 2/23/1914 Washington, DC Usual Residence of Decedent or 28a-f show notified at 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location filed within 72 hours after death with the Maryland Director 1 🗆 Yes 2 ឺ No Maryland Anne Arundel Annapolis 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 5 ms 23a or must be r Funeral USA 21401 1804 Lindamoor Lane items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 14. Race - American Indian. ural", or iten I Examiner n 11, Marital Status Yes, specify Cuban, Mexican, Puerto Rican, etc. 1 Never Married 2 X Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White "natural", 3 Widowed 4 Divorced Completed Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working permit, Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene, Important: If item 27 is marked other than ", any injury or other traumatic event, the Med Once. 5+^{College (1-4 or 5+)} life, DO NOT use retired) than Elementary/Secondary (0-12) Captain US Navy Military Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ John Russell VerBrycke, Jr. Barnes Sophia 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara P. VerBrycke/Wife 1804 Lindamoor Lane, Annapolis, MD 21401 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Kalas Crematory 3/8/2012 Edgewater, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility George P. Kalas Funeral Home 21. Signat of Funeral Service License 2973 Solomons Island Rd. Edgewater, MD 21037 that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, on each line. . Part 1. Enter the disease, or complications shock, or heart failure. List only one cause Interval Between Onset and Death Immediate Cause (Final P___ician/ BLEEDING GASTRO INTESTINAL disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examine Due to (or as a consequence of) if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi and Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 the attending pl IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death Yes 2 No been signed by the s should be detached 1 ☐ Yes 2 ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown DEMENTIA ALZ HEI MERS 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 No page 2 has certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medica 26. Place of Death (Check only one) funeral director Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No npatient 2 ER/Outpatient 3 DOA မ within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Dav. Year) D0051487 8019

Registrar
DHMH 17 Rev 06-2011

State

10. 2001 Medical PArkwar

of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day Year) 8 2012

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State of Maryland / Department of Health and Mental Hygiene 2 0 | 2 09226 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ ^{Day} 2012 Catherine Chepuras Vaniglio 2, March 1:40 A Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** Casey House Rockville Montgomery 8. Date of Birth (Month, Day, Sept. 13 If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number Age (In yrs. last birthday) 6. Sex **Funeral** Country)
Washington. DC Days 1 □ M 2🕱 F Months Hours Director 579-07-1027 1915 96 Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County filed within 72 hours after death with the Maryland Director 1 Yes 2x No North Potomac Montgomery 10e, Street and Number 10g, Citizen of What Country? Funeral 13532 Travilah Road 20878 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Specify: White Completed 3 Widowed 4 X Divorced Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Book Artist Book Arts other traumatic event, Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) t, Page 1 and 2 should be filed tment of Health and Mental H rant: If item 27 is marked oth Samuel Nicholas Chepuras Garafalia Stathouli 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Stephen Vanilio/Son 13532 Travilah Rd., North Potomac, Md. 20878 20b. Place of Disposition (Name of cemetery, crematory or other place) ukn 20c. Location - City or Town, State Washington 20a. Method of Disposition Date permit, Page 1 a Department of H Important; If ite any injury or ot 1 🛣 Burial 2 🗌 Cremation 3 🗌 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Glenwood Cemetery 3-27-2012 22. Name and Address of Facility DeVol Funeral Home uneral service Licenses Signature MO1315 You Hall Ave., NW., Washington DC 20007 2222 Wisconsin 23a. Part 1, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death
Years Immediate Cause (Final Ph_ician/ Dementia disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): and -name Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician I for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 \square Live Birth 2 \square Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Pregnant at time of death 5 Other (specify) Vac 2 XNo sate has been signed by the page 2 should be detached 9 Unknown Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy this certificate has performed? 1 Yes 2 No Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director. Be Hospital Other: $4 \square$ Nursing Home $5 \square$ Residence $6 \times$ Other (Specify) Hospice 1 ☐ Yes 2 🗓 No 1 Inpatient 2 ER/Outpatient 3 DOA မှ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: within 24 hours after death.

To the Funeral Director: After completed filled in by the funeral injury work? 1 ☐ Yes 1 X Natural 5 Pending 2 🗌 No ☐ Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the 29b. Signature and title of certifie D0060634 March 2, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bindu Joseph, M.D. 1355 Piccard Rd., #100, Rockville, Md. 20850 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAR 0 9 201

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	Otato of Mary	Cer	tificate of L	Death		Reg. N	.201	2	0922/
	Physicia	n/	1. Decedent's Name (First, Middle, La.					2. Date o Month March		Day 2012 ^{Ye}	ar	3. Time of Death
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أمريت	Examin	er	Alfred House-Ro			Rockvi		Joan		ontgome		
	Funeral		5. Social Security Number 6. S		yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hours		Birth Day, Year	9.	Birthpl Countr	ace (State or Foreign
	Director		219-42-2777 Usual Residence of Decedent	¹³ M 2 □ F 67	Yrs.			Oct.	20, 1	944	MI)
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	e Many 28a- notifie	Sirec	MD Montg	omery	Rockvi							1 🗌 Yes 2 🐔 No
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	leath v items er mu	Funeral Director	5313 Norbeck Ro	12, Was Decedent Ever	in U.S. 13, V	Vas Decedent of H f Yes, specify Cuba	ispanic Origin	? (Specify Yes or	No-	14. Race - /	11. 14	
9036	urs after o ural", or i	ted by	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates.		Yes 2 No		dorto riidari, ete.,		Black, V Wh Specify:	ite, ei	ic.
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yland	ld be filed Mental Hy arked ott	To Be	17. Father's Name (First, Middle, Last) Frederic Donald	Vechery				Anna Th		n Surname)		
Baltimore, Maryland 21215-0036	ge 1 and 2 should be filed within 72 hours after death with the Manyland nt of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at		19a. Informant's Name/Relationship (19a Henry H. Vechery		19b. Mailin 6208	g Address <i>(Street a</i> Clearwood	and Number o	or Rural Route Nu Bethes	mber, City da, M	or Town, State ID 2081	, Zip Co 7	ode)
more	Page 1 ar nent of He int: If iter iry or oth		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Special Control of the Contr	Removal from State	20b. Place of Dispo cemetery, cren Fort Linc	natory or other plac	i Pi	$\begin{array}{c} { t Date} \\ { t arch} & 10 \\ 2012 \end{array}$		Location - Cit	-	
Balti	permit. Page 1 a Department of H Important: If ite any injury or ot once.		21. Signature of Funeral Service Licen		F1	Name and Address	ss of Facility	ns Fune:	ral H Sil	ome Ind	ing	, MD 20901
			23a. Part 1. Enter the disease, or comshock, or heart failure. List only of							W. 164		Approximate Interval Between
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687	ertifica ding p ise as t		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of p	pregnancy					23d. Date o	f delive	
. Box	e death certi the attendin ched for use	Physician/	in the past 12 months? 1 Yes 2 No 9 Unknown	1 ☐ Live Birth 2 ☐ 4 ☐ Pregnant at tin 9 ☐ Unknown		Ectopic pregnand Other (specify)	:y		- 5	Month		Day Year
s, P.O.	ires that the deat signed by the at d be detached fo	þ	Part II. Other significant conditions of	contributing to death but n	not resulting in the u	nderlying cause giv	ven in Part I.					e cause of death? ably 4 🗗 Unknown
ord	w require s been sig 2 should b	Completed							Vas an			sy findings available apletion of cause of
Be	nysician: The law is certificate has t	Com							performed? Yes 2 🔀	deat	h?	2 No
ita	ician: certific rector,	Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:		— Oth		(Check only one)		Assis	sted	Living
) t	ding Phys th. After this funeral di	e: To	27. Manner of Death	28a. Date of injury	2 ER/Outpatier 28b. Time of	nt 3 □ DOA [28c. Injur	y at	ing Home 5 1		6X Other (Surred	pecify)	
on	ending eath. or: Afte the fur	ficat	1 Natural 5 Pending 2 Accident Investigation		ear) injury	M 1 □	Yes 2 N	0				
Division of Vital Records,	ial or Attendi s after death al Director: A ed in by the f	l Certificate:	3 ☐ Suicide 6 ☐ Could not I 4 ☐ Homicide determined			eet, factory, office			on (Street a Town, Sta		r Rural I	Route Number,
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours afferd cleath. To the Funeral Director: After this certificate has been signed by the attending physician and To the Funeral Director: After this certificate has been signed by the attending physician and To the Funeral Director, page 2 should be detached for use as the burial that the funeral director, page 2 should be detached for use as the burial that the funeral director and	Medical	(Check 2 Medical Exam	vician: To the best of my niner: On the basis of examiner Practitioner: To the be	nination and/or invest	tigation, in my opinio	on, death occu	irred at the time, d	ate and pla	ce, and due to	the caus	se(s) and manner stated.
	with with Total		29b. Signature and title of certifier	- Il ame	en	I	254	10		Date signed (M		
			30. Name and address of person who Oliver Lawless,	ompleted cause of death MD 18111	h (Item 23a) (Type, F Prince Pl		310 , 01ne	ey, MD 20	0832			
	Sta Registr		31. Date filed (Month, Day, Year) MAR 0 9 2012	32. Registrar's	Signature Sack	9.						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ March 7, 20 12 11:30 p M Marie Louise Weight Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Calvert Solomons Nursing Center Solomons Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 DM 2 Months Days Hours June 23, 1915 Country) **Director** 96 134-10-9909 Usual Residence of Decedent 10a. State 10b. County or than "natural", or items 23a or 28a-f shorthe Medical Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Calvert Solomons 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20688 USA 13325 Dowell Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian, Armed Forces? 1 Yes 2 No Black, White, etc. ģ 1 Never Married 2 Married 1 ☐ Yes 2X No Specify. If Yes, Give Year or Dates 3 Widowed 4 Divorced Specify. Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired. Elementary/Seconday (0-12) College (1-4 or 5+) Federal Government Translator Be other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Department of Health and Ment: Important: If item 27 is marked any injury or act. Marie Miga John Ingrahm 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 256 Claremont Court Arnold, MD 21012 Michael J. Weight - grandson 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory March 9, 2012 | Alexandria, VA 22. Name and Address of Facility Sewell Funeral Home, P.A. Hoshone 1451 Dares Beach Rd. Prince Frederick, MD 20678 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ HRONIE disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate Examir Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FFMALE 23c. If yes, outcome of pregnancy 1 \square Live Birth 2 \square Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Year Month Day Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy page death? Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 2 X No Other ျပ 1 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA oxtimesNursing Home 5 \Box Residence 6 \Box Other (Specify) 27. M n er of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending

The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 Hospital or Attending Physician: 28a-f shov

hours after

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After this

neral Director: /

Medical

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☐ Accident ☐ Suicide

29a. Certifier

Maryland 21215-0036

Baltimore,

JRW 4

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MD 001942

1 ☐ Yes 2 ☐ No

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Investigation

determined

6 Could not be

RD. PRINCE FREDERICK MUNSHI M.D. 130 HOSP

28f. Location (Street and Number or Rural Route Number,

City or Town, State)

State Registrar 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

		Pleas	se Type or Pri					_		Legible	•	
		For State	State of M	laryland /		artment of F		Viental Hy	giene	0.01	2 2 2 2	
_		Registrar 1. Decedent's Name (First, Middle, I	(ast)		Cer	tificate of L	Jeain	2. Date of Dea	Reg. No.	201	4,092	29
Physicia Medic	al	Virginia h	! White	ehead	/			Month	Day 6	2013		A M
Examin	er	4a. Facility Name (if not institution, of Shady Grove Adv	iendist Eme	,		Germo	Location of Death			County of Dea	omery	
Funeral Director		577-16-9987	5. Sex 1 □ M 2 🙀 F	ge (In yrs. last bi 95	irthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bird (Month, Da Aug. 3	th y, Year) 191	.6 I11	thplace (State or Fo untry) Inois	oreign
how at	٦	Usual Residence of Decedent 10a. State 10b. County		10c. City, Tov	wn or Loc	cation					10d. Inside City L	_imits
/laryla 8a-f s tiffied	Funeral Director	Maryland Montgo	mery	Germa	antov	vn.					1 ☐ Yes 2	
h the had a or 2 be no	al Di	10e. Street and Number				10f. Zip Code			10g. Citi:	zen of What Co	ountry?	
ath wit	uner	18810 Liberty M	111 Road	Suprin II S	112 1/	2087 Vas Decedent of Hi		posify Voc or No		Inited		
2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at	ρ	11. Marital Status 1 ☐ Never Married 2 ☐ Marrie	Armed Forces?		If	f Yes, specify Cuba	ın, Mexican, Puerto	Rican, etc.)		14. Race - Ame Black, Whit Specify:	e, etc.	
atural	eted	3 Widowed 4 □ Divorced 15. Decedent'	Year or Dates.	16		lent's Usual Occup				nd of Business	White	
hin 72 h Je. Ithan "n e Medi	Completed	(Specify only highest Elementary/Seconday (0-12)		5+)	(Give k life. DC	kind of work done of NOT use retired)	during most of worl	king	Fede	eral Go	vernment	/
ed witl Hygier other i	BeC	17. Father's Name (First, Middle, Las	st)	H	Execu	utive Sec	18. Mother's Nam	ne (First Middle		White	House	
ld be file Mental arked o	₽	Charles M. Wesn						Grubbs				
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name/Relationship Virginia Whiteh		/_ \		g Address (Street a			-			
of Heal of Heal of item 2		20a. Method of Disposition 1 ☐ Burial 2 🔀 Cremation 3	Pameyal from State	20b. Place	of Dispos	sition (Name of		hate 07,		cation - City or		
t. Page tment o tant: If jury or		4 Donation 5 Other (Sp.	ecify)	Met C	remai		20	12			, Virgin	ia
permit. Departr Import: any inju		21. Signature of Funeral Service Lice		0689		Name and Addres Bast De					g, MD 20	877
40.00000000		23a. Part Fit the disease, or conhock, rrant ailure. List onl	omplications that cause ly one cause on each lin	ie.					rest,		Approximate Interval Betwee Onset and Dea	
Physician/ Medical		disease or condition resulting in death)	pa. Hcute Due to (or as	a consequence	CQV e of):	chal I	ntarcti	01			minutes	
Examiner	er	Sequentially list conditions, if any, leading to immediate	b. Hype:	a consequence	e off:						years	
and -traff	Examiner	cause. Enter Underlying Cause (Disease or iinjury that initiated events	. Hyper			olemia					years	
be ey siciar buria	ज्ञ	resulting in death) Last	Dué to (or as	a consequence	e of):							
ificate ig phys as the	Medi	IS ESTABLE.	— d									
eath certificate b attending physi I for use as the b	Physician/Medio	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 Live Birth			Ectopic pregnand Other (specify)	Э		2	23d. Date of de	livery Day Yea	r
the dea	hysi	1 Yes 2 No 9 Unknown	g 🗌 Unknown			Other (specify)						
ires that signed b	þ	Part II. Other significant condition	s contributing to death I	but not resulting	g in the u	nderlying cause giv	ven in Part I.	23e. Did to			o the cause of deat Probably 4 Unl	
w requ	olete							24a. Was			topsy findings ava	
The lar ate ha	Completed							autor perfo	rmed?	death?	completion of caus s 2 🛣 No	se oi
ician: Sertific ector,	Be	25. Was case referred to medical examiner?	Hospital:	21		Oth	ace of Death (Chec	ck only one)		-		
Phys r this eral dir	e: 10	1 ☐ Yes 2 🔀 No 27. Manner of Death	1 ☐ Inpat		. Time of	at 3 DDA 28c. Injury	4 ☐ Nursing H	ome 5 Resid			cify)	
ending sath. or: Afte he fun	ficat	1 Natural 5 Pending 2 Accident Investiga	ation	ay, Year)	injury	M 1 □	? Yes 2 🗆 No					
Il or Atta after de Directo	Certificate:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	28e. Place of Inj	jury - At home, t tc. <i>(Specify)</i>	farm, stre	eet, factory, office	-	28f. Location (5 City or Tox		Number or Ru	ral Route Number,	
To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompleted filled in by the funeral director, page 2 should be detached for use as the	Medical	(Check 2 Medical Ex	Physician: To the best of aminer: On the basis of a Nurse Practioner: To the	examination and	/or invest	tigation, in my opinio	on, death occurred a	at the time, date a	and place,	and due to the	cause(s) and manne	er stated.
Northi Post		29b. Signature and title of certifier	7 V. O. 90)		29c. License	number 5 / 79 /		29d. Date	e signed (Mont	h, Day, Year)	2_
		30. Name and address of person with a range L. K. Le 31. Date filed (Month, Day, Year) MAR 0 9 201	no completed cause of	death (Item 23a)	GP 6-	mantous	tist En Road.	sergeno Germa	ntou	enter n, MD	20874	/
Stat Registra	e ir	31. Date filed (Month, Day, Year) MAR 0 9 201	32. Registr	rar's Signature	bare	y					,	"
			-	1. 13			-					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 3. Time of Death Physician/ Day 2012 Month Charlotte March 9:31 Coppage Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Keswick Nursing Home Baltimore Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** Age (In yrs. last birthday) 9. Birthplace (State or Foreign Hours Min. Country) **Director** 220-24-4515 95 Usual Residence of Decedent 05/30/1916 Maryland shov 10b. County "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 15 Malibu Court 21204 United States death \ Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Bace - American Indian Black, White, etc. þ 1 Never Married 2 Married Yes 2 X No Yes, Give Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed 3 X Widowed 4 Divorced Specify: Year or Dates White Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) of Health and Mental Hygiene. Item 27 is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) other traumatic event, the 4 Teacher <u>Education</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Harry Ross Coppage Mable Estelle Fallin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles A. Young III/Son 15 Malibu Court, Baltimore, MD 21204 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of I Important: If ite any injury or ot once. Date St. George Episcopal Cemetery 1 A Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 03/16/2012 | Valley Lee, MD 21. Signature of Funeral Service Livensee

Kathleen Santivasci M00 22. Name and Address of Facility Brinsfield Funeral Home, P.A. M00872 22955 Hollywood Road, Leonardtown, MD 23a. Part 1, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Priysiciani disease or condition resulting in death) Clementia Medical Due to (or as a consequence of): ≟xaminer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami use as the burial-transi Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ 23d. Date of delivery 1 ☐ Live Birth 2 ☐ Fetal 2 4 ☐ Pregnant at time of death in the past 12 conths?

1 Yes 2 No Year Day 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ

signed by the peen : has page 2 s 24 hours after death.

Funeral Director: After this certificate betely filled in by the funeral director, page

Completed

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Certificate:

Medical

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only one

deBillTy 1 ☐ Yes 2 ☐ A 3 ☐ Probably 4 ☐ Unknown hypertension unjective heart Failure 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No death? 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury work? 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 29a. Certifier 🗓 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated,

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29a License number D39102

12,2012

Marcit

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

(9) eme State

Division of Vital Records,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

700 WEST 40th Street Baltimore Mary HILLAN DON MI.D.

31. Date filed (Month, Day, Year)

Welly On the

Registrar

within 2

To the I

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 () | 2 Certificate of Death 1 Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death 10:26 P_M Physician/ Martch 6, Da 2012 Year Irving YORK Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery 7 Argosy Circle Gaithersburg If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Newntry ork 5. Social Security Number 6. Sex. 1 M M 2 □ F 7. Age (In vrs. last birthday) **Funeral** Hours Dec. 18, Yea 1927 84 Director 112-22-4663 Usual Residence of Decedent 28a-f show or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 XNo Gaithersburg Maryland Montgomery 10e. Street and Number 10g. Citizen of What Country? Funeral United States 20878 7 Argosy Circle 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 X Married 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Year or Dates. WW II Specify: white 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry I Hygiene. other than "r Elementary/Seconday (0-12) College (1-4 or 5+) Contract Administrator/Lawyer|International permit. Page 1 and 2 should be filed wit Department of Health and Mental Hygie Important: If item 27 is marked other 1 any injury or other traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Anna Kaplan Samuel York 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Ryral Route Number, City of Town, State 27, Code)
7 Argosy Circle, Gaithersburg, MD 20878 Joyce York, Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Bunal 2 Cremation 3 Removal from State Judean Memorial Gardens 03/08/12 Olney, MD Donation 5 Other (Specify) Mertanopoabirtam Fabruneral Service, Inc. 21. Signature of Funeral Service Licensee 5517 Vine St., Alexandria, VA 22310 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Parkinson's Disease Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Dementia Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Slotan care that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physiciar Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

4 Pregnant at time of death 5 Other (specify) ISe 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Hospital or Attending Physician: The law requires Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🌠 Unknown 24b. Were autopsy findings available prior to completion of cause of death? performed? Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 **X** No ပ 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA s after death.

I Director: After this od in by the funeral di Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 XNatural 2 Accident 3 Suicide 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation 6 Could not be To the Hospital or Atte within 24 hours after de To the Funeral Directo completed filled in by tt 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

P.O. Records, Division of Vital

12+1

State

Registrar

Jeffrey Sherman, M.D., 2021 K St., NW, #404, Washington, DC 31. Date filed (Month, Day, Year) MAR 0 9 2012

29b. Signature and title of certifie



rerman

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

M.D

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

March 7, 2012

20006

29c. License numbe

D 37059

State of Maryland / Department of Health and Mental Hygiene 🤈 🗋 for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Gary Leon Zimmerman, Sr. March 8 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 20720 El Rancho Road Boonsboro If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 1 X M 2 D F 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** (Month, Day, Year) ov 7, 1946 Days Hours Min. 65 Yrs. Director 215-44-9968 Nov Usual Residence of Decedent 28a-f show 10a. State 10h County 10c. City. Town or Location must be notified at Director Maryland | Washington Boonsboro 0 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 20720 El Rancho Road S.A. 21713 12. Was Decedent Ever in U.S. Armed Forces?
1 X Yes 2 \sum No 1965-13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 0 þ 1 Never Married 2 X Married within 72 hours after Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify "natural" 3 Widowed 4 Divorced Specify: Completed 1971 Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72 Is and Mental Hygiene.
7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) the Material Handler other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٩ .Iohn Will Zimmerman Fannie Mae Ebersole 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 si f Health a 27 Donna L. Zimmerman/wife 20720 El Rancho Road Boonsboro, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Department of H Important: If ite any injury or ot 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 03/12/2012 Samples Manor Cem. 21. Signature of Funeral Service Licens 22. Name and Address of Facility Bast-Stauffer Funeral Home, PA 7606 Old National Pike Boonsboro, MD 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ hulonsi disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Pregnant at time of death 2 No signed by the a 1 ☐ Yes 2 ☐ 9 ☐ Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Records, 24a. Was an autopsy page Yes 2 -10 25. Was case referred to medical examiner?

1 Yes 2 No Be Division of Vital funeral director, 26. Place of Death (Check only one) Hospital Other: 4 \(\sum \) Nursing Home 5 \(\overline{\text{Aesidence}}\) 6 \(\sum \) Other (Specify) ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No hours after death.

neral Director: Aft
d filled in by the fur 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier pleted Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier Muchael 041667 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JW-5+1 Medical Camos Michael MClo

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 3. Time of Death Year :19 Washington Birthplace (State or Foreign Country) Maryland 10d. Inside City Limits 1 Yes 2X No 14. Race - American Indian, Black, White, etc. White 16b. Kind of Business Industry Manufacturing 21713 20c. Location - City or Town, State Sharpsburg, Maryland Approximate nterval Between Onset and Death 23d. Date of delivery 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 29d. Date signed (Month, Day, Year)

State Registrar 11110

Mack 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 | | 2 for State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2012^{eai} March 4:10A.M Sandra Rudel Zwillinger Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Suburban Hospital Bethesda 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Oct. 14, 1931 9. Birthplace (State or Foreign **Funeral** Days New York Director 550-40-5122 1 □ M 2 🏋 F 80 Usual Residence of Decedent 28a-f shov 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location the Medical Examiner must be notified at Director Bethesda Maryland Montgomery 1 ☐ Yes 2X No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ō Funeral items 23a 5450 Whitley Park Terrace 20817 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? ō þ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2X No Specify: Specify: White If Yes, Give Year or Dates "natural", 3 X Widowed 4 □ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) I Hygiene. College (1-4 or 5+) Elementary/Secondary (0-12) Stock Broker Financial should be filed with and Mental Hygien is marked other th injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Max J. Glickman Eva Turk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jensey S. Jensey Marc Zwillinger -son 8513 Rayburn Road Bethesda, Maryland 20817 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Gdn. of Remembrance 20a. Method of Disposition 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State 3/11/2012 4 Donation 5 Other (Specify) Clarksburg, Maryland 21. Signature of Funeral Service Licer Bonald V. Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705 WBa 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final tarena Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner 0 Cause (Disease or injury that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician for use as the burk Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 month 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Month Day Year Pregnant at time of death the signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform cate has by page 2 s Rudel-Zwillinger 2 No 1 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 \(\subseteq \text{Nursing Home} \) 5 \(\subseteq \text{Residence} \) 6 \(\subseteq \text{Other} \) Other (Specify) 1 Yes ပ 1 Inpatient 2 XER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of Certificate: 28d. Describe how injury occurred 5 Pending Natural Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie who completed cause of death (Item 23a) (Type, Print) SERRETOWN RD. BETHESDA, MD State MAR 0 9 2012 Registrar

Sandra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items State of Maryland / Department of Health and Mental Hygiene Per me, 9925,03721/2012dhb Reg. No. 1 - For State Registrar 2 Date of Death 1. Decedent's Name (First, Middle, Last) Month Physician at /Medical 4c. County of Death Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner 1-evsv11 Knollwood uanor If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, April 5, 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday, 5. Social Security Numbeunk 6 Sex Year) 1959 Country) Nigeria **Funeral** Hours Min. Days Months 1 □ M 2 🗓 F 52 Director Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10c. City, Town or Location unk 10a. State unk 10b. County unk 28a-f show at unkt □Yes 2□No r than "natural", or Items 23a or 28a-f shipe Medical Examiner must be notified Directi 10f. Zip Code unk 10g. Citizen of What Country? unk 10e. Street and Number Nigeria Funeral 14. Race - American Indian, 11. Marital Status unk Black, White, etc permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Item any Injury or other traumatic event, the Medical Examiner Specify: black 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 þ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 16b. Kind of Business/Industry Un Completed 16a. Decedent's Usual Occupation UTI (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) unk unk 18. Mother's Name (First, Middle, Maiden Surname) unk 17. Father's Name (First, Middle, Last) Be ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type. Print) 2666 Riva Rd 3rd flr; Annapolis, MD 21401 Janice Holland - legal guardian 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 Nother (Specify) in state 22. Name and Address of Facility State Anatomy Board of Funeral Service Licensee Ronald 8 Director 655 W. Baltimore St; Baltimore, MD 21201 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) month **Physician** /Medical Due to (or as a consequence of): month Examiner L Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner ADMONED BY MEDICAL POSTUMES Due to (or as a consequence of) for 17 e as the burian Physician/Medical CERTIFICAT attending phys. IF FEMALE Box 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery that the death cu 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Day Year in the past 12 months? 5 ☐ Other (specify) ed by the a 本 ス 3 グナ ん Division or Vital Records, P.O. 9∏Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Únknown icate has been sig , page 2 should b 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 🗸 1□ Yes certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one) After this certific funeral director, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ER/Outpatient 3 DOA ဥ 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death Drug container ruptured in digestive tract Certification: Injury To the Hospital or Attending 5 ☐ Pending investigation uvatural 1 Yes 2 No ithin 24 hours after death.

the Funeral Director: Af
ompletely filled in by the fur 2X Accident Unknown M 2010 6 □ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 Homicide Found: Maryland Unknown 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 2

State Registrar 31. Date filed (Month, Day, Year)
MAR 2 6 2012

32. Pegistrar's Signature

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30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month Year IRGINIA AVGERINOS 10.01PM Mar 2012 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore Kandallstown Hospita VorthWest If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) 152-39-1961 95 1 □ M 2 □XF June 27, 1916 Jersey New Usual Residence of Deced 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 X No Carroll Sykesville 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 7200 Third Avenue, # 7 21784 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Yes 2 X No If Yes, Give Year or Dates. 1 Yes 2 X No Specify: White Specify. 3 XWidowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Chorlios Thomas Helen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11110 Chambers Ct., Unit J, Woodstock, MD 21163 Dennis Avgerinos-son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Greek Orthodox Woodlawn, MD 3/26/12 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fyneral Service Licensee William G. 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. Dau 1050 York Rd., Towson, MD 23a. Part 1. Enter the disease, or com shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death) 23b. Was decedent pregnant

Ph_{sician}/ Medical Examiner Examine

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After this

Funeral Director:

within 2 To the

Hospital or Attending Physician:

Physician/Medical

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Completed

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Certificate:

The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760

Physician/

Medical

10a. State

MD

Examiner

Funeral

Director

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death v

Baltimore, Maryland 21215-0036

ar than "natural", or items 23a on the Medical Examiner must be

permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me

notified at

Director

Funeral

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Completed

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Sequentially not conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE:

ne cause on each line. A cute Mye cardial Infarction	Approximate Interval Between Onset and Death
Due to (or as a consequence of): Gastrointestinal Bleeding	
Due to (or as a consequence of): c. Pheu monia Due to (or as a consequence of):	
d	
23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)	23d. Date of delivery Month Day Year

in the past 12 months? 2 × No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 26. Place of Death (Check only one)

23e.	Did tobaco	co us	se cont	tribute to the cau	se of death?
	1 🗆 Yes	2 [No	3 Probably	4 🔀 Unknown
24a	Was an		24b.	Were autopsy fin	dings available

1 🗌 Yes	2 [No	3 Probably	4 🔀 Unknown
la. Was an autopsy	0	24b.	Were autopsy fin prior to completi	idings available ion of cause of

1 ☐ Yes 2 🗷 No

25.	Was case referred to medical examiner? 1 ☐ Yes 2 🔀 No
27.	Manner of Death

) 5	spital:	1 🛣 Inpatient	2 🗆	ER/Outpatient	3 🗆 1	DOA	Other:	4 🗆	Nursing F	lome	5 Residence	6 🗌 Other	(Specify
		Date of injury (Month, Day, Ye		28b. Time of injury			Injury at work?			28d.	Describe how in	jury occurred	d .

1 Natural	5 ☐ Pending
2 Accident	Investigation
3 Suicide	6 Could not be
4 Homicide	determined

. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injury at work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury occurred
Place of Injury - At he		tory, office	28f. Location (Street and Number or Rural Route Number,

4	1 Homicide	determined	28e. Place of Injury - At home, farm, street, factory, off building, etc. (Specify)
29a.	Certifier	1 K Certifying Physic	ian: To the best of my knowledge, death occurred at the

Dung	ing, etc. (apachy)	City of Town, State)	
Certifying Physician: To the b	pest of my knowledge, death occurred at the time, date	e and place, and due to the cause(s) and manner as stated.	
Medical Examiner: On the ba	sis of examination and/or investigation, in my opinion, dea	ath occurred at the time, date and place, and due to the cause(s) and mar	nner state

Road, Randallstown

I ☐ Yes 2 🗷 No

only one) 3 🗆 (Certifying Nurse Practitioner: To the best of my	y knowledge, death occurred at the time, date and place, and d	ue to the cause(s) and manner as stated
29b. Signature and title	. /	29c. License number	29d. Date signed (Month, Day, Y
> Au	all HD	D67325	Har, 22, 2

(Check

	29c. License number
D	D67722

	29d. Date	signed (Mo	onth, Day,	Year)		
ł	U.	. 4	4)	2 4	. 0	

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State	31. Date filed (Month	, 1

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Old Court 5401

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2012 Year Physician/ March 20, 10:41 A M Mary C. Brown Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Silver Spring Montgomery Renaissance Gardens If Under 1 Year I If Under 24 Hrs. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Davs Hours 192-14-7531 Director 1 □ M 2 🔀 F 88 June 4, 1923 Pennsylvania Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location notified at Director 28a-f s 1 X Yes 2 No Maryland Montgomery Silver Spring 10e. Street and Number or 10f. Zip Code 10g. Citizen of What Country? Examiner must be 23a Funeral 20904 U.S.A. 3160 Gracefield Road or items death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces Black, White, etc. 1 Never Married 2 Married 2 X No 2 Maryland 21215-0036 72 hours after 1 Tes 2 No Specify: Specify: White If Yes, Give 'natural", 3 ₩ Widowed 4 □ Divorced Completed Year or Dates event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) than Elementary/Secondary (0-12) College (1-4 or 5+) and Mental Hygiene. is marked other tha 12 Rental Agent Real Estate Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Ment.
Important: If item 27 is marked any injury or other. Helen Grady Joseph Curry 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Constance Masciangelo (Daughter) 10341 Tanglewood Dr., Huntingdon, PA 16652 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Bertal 2 Cremation 3 Re 3/24/2012 St. John Neumann Chalfont, PA Donation 5 D Other (Specify) nature of neral Service Liv 22. Name and Address of Facility Metropolitan Funeral Service 5517 Vine St., Alexandria, VA 22310 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Retween Immediate Cause (Final 2 Weeks Ph_sician Cerebral Vascular Accident disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Arteriosclerotic Cerebral Vascular Disease 10 Years Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed and -tran that initiated events resulting in death) Last Due to (or as a consequence of) physician a s the burial-Physician/Medical Box 68760 as IF FEMALE: ase 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No for Day Month Year the g Unknown P.0. by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Metastatic Colon Cancer Division of Vital Records, 1 ☐ Yes 2X☐ No 3 ☐ Probably 4 ☐ Unknown Completed Atrial Fibrillation 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed' certificate 1 Yes 2 No Yes 2 X No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 1 🗌 Yes 2 🗓 No Other: ည 4 X Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred eral Director: After if filled in by the funer 1 🛚 Natural 5 Pending death. 1 Yes 2 🗌 No 2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2

To the I

comple 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar

32. Registrar's Signature

Eileen Gemmell, CRNP

31. Date filed (Month, Day, Year)
MAR 2 6 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Eileen Gemmell, CRNP 3160 Gracefield Rd., Silver Spring, MD 20904

			-	For State Registrar	State of M	aryland		tificate of E				Reg. No	20	12	09237
		nysicia Medic		1. Decedent's Name (First, Middle, La Gracie D	Beck						2. Date of De March		20	Year	3. Time of Doub
	E	xamin		4a. Facility Name (if not institution, given Doctor's Commun.	<i>'</i>	al		4b. City, Town, or Lan		of Death		40.	County of		eorge's
	Dir	ineral ector		5. Social Security Number 578–48–9487 Usual Residence of Decedent	Sex 7. Ag ☐ M 2 🔀 F	e (In yrs. las	t birthday) Yrs.	If Under 1 Year Months Days	If Under Hours	Min.	8. Date of Bir (Month, Da	ay, Year)		Count	lace (State or Foreign ry) orida
	aryland	a-f show ified at	ector	10a. State 10b. County Maryland Prince	George's		Town or Loc		er Ma			, .	,,,,,		Od. Inside City Limits 1 X Yes 2 No
	with the M	23a or 28 ist be not		10e. Street and Number 308 Fidgeway Lan				10f. Zip Code 2077		11100			tizen of Wh		
	Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.	ural", or items al Examiner mu	۵	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 Yes 2 II If Yes, Give Year or Dates.		If	/as Decedent of Hi Yes, specify Cuba	spanic Oriç n, Mexican	, Puerto Ri	fy Yes or No- can, etc.)		14. Race - Black, Specify: A	- America White, e	an Indian, tc. can
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	and 2. be filed wit ntal Hygie	ed other	To Be C	17. Father's Name (First, Middle, Last)	5+ in Dukes			College			First, Middle,		Surname)	vate.	2
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3	Baltin permit. P Departm	Importar any injur once.		21. Signature of Funeral Service Licen	**	M005	-	Name and Addres		y Ste	wart F	uner	al Ho	ome,	
	-∼Physi	ician/		23a. Part 1. Enter the disease, or comshock, or heart failure. List only of Immediate Cause (Final disease or condition	one cause on each line	d the death.	Do not enter	the mode of dying	g, such as	cardiac or	respiratory ar		cony		Approximate Interval Between Onset and Death
		edical miner	<u>.</u>	resulting in death) Sequentially list conditions,	Due to (or as	a conseque CPh	nce of): .a 10)	1 BI	/						
	cate be executed	cian and ourial-transit	al Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): **Respiral for Y Failure** Due to (or as a consequence of): **Due to (or as a conseq											
6	ညာ မွဳ ဋ	for use a		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	d								of delive	ry Day Year	
	S, P.O.	oe de	ह		tions contributing to death but not resulting in the underlying cause given in Part I. TUMOUV					l.					e cause of death?
,	DIVISION Of VITAL RECORDS, all or Attending Physician: The law requires safter death.	page 2 should	Completed								24a. Was auto perfo		pri		sy findings available inpletion of cause of
	Vital F ysician: T		To Be C	25. Was case referred to medical examiner? 1 Yes 2	Hospital: 1 Inpati	ent 2 🗆 Ei	R/Outpatient	1	ace of Deat						2 🗆 140
•	SION OT ttending Ph death.		Certificate:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident Investigatio 3 ☐ Suicide 6 ☐ Could not be	28a. Date of inju (Month, Day	ry 2	8b. Time of injury	28c. Injury work	at ? Yes 2 🗆		ld. Describe h	how injur	y occurred		
	DIVISIO ital or Attenurs after deat	completely filled in by the		4 Homicide determined	building, etc	c. (Specify)					City or Tov	vn, State,)		Route Number,
	DIVIS To the Hospital or At within 24 hours after of	me rune npletely fi	Medical	(Check 2 Medical Examonly one) 3 Certifying Nur	sician: To the best of iner: On the basis of e se Practitioner: To the	xamination a	and/or investi	gation, in my opinio death occurred at th	n, death oc ne time, dat	curred at the	ne time, date a	and place the cause	, and due to e(s) and mar	o the caus	se(s) and manner stated. tated.
1	N With	o o		29b. Signature and title of certifier fan	Alem			29c. License	909			2	te signed (/	2/1	2
1			_	30. Name and address of person who FASI Alemu 31. Date filed (Month, Pay Year)				Luck R	DAI),	LAN	han,	MA	20	701	6
1X	Re	Stat egistra	ır	31. Date filed (Month, Day, Year) MAR 2 6 2012	32. Registra	ar's Signatur	arke						<u>-</u> -		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 19^{Day} 2012 Year March Dorothy Simpson 7:05 A Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. Counfy of Death Taneytown Lorien of Taneytown Carroll If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) NOV 5, 1917 Social Security Numbe Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Maryland Director 94 214-16-1417 Usual Residence of Decedent 28a-f show 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits or other traumatic event, the Medical Examiner must be notified at Director Carroll Westminster 1 Yes 2 X No MD 23a or 2 10f. Zip Code 10g. Citizen of What Country? Funeral 21157 354 Sunshine Way USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian. 0 þ 1 Never Married 2 Married Yes Yes, Give 2 XNo 1 Yes 2 XNo Specify. Specify. "natural", Completed 3 X Widowed 4 □ Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) 2 should be filed within 72 hand Mental Hygiene.
7 is marked other than "n Elementary/Seconday (0-12) College (1-4 or 5+) clothing mfg. seamstress 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Grace Johnson Guy J. Simpson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) . Page 1 and 2 sl ment of Health a tant; If item 27 is 352 Sunshine Way, Westminster, MD 21157 Audrey Bowers - daughter 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important; If ite 1 Burial 2 Cremation 3 Removal from State Haugh's Cemetery Ladiesburg, MD injury o 4 Donation 5 Other (Specify) 3/22/2012 Signature of Funeral Service License 22. Name and Address of Facility Hartzler Funeral Home Droynell 6 E. Broadway, Union Bridge, MD 21791 23a, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dving, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Heart Physician/ Congestive disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Donust Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Exami burial-transi Due to (or as a consequence of): physician the burial Physician/Medical that the death certificate be 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Month Dav Year Pregnant at time of death signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≥ cutery COSUNAN, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed death? No No 2 Yes 25. Was case referred to medical To the Hospital or Attending Physician: 26. Place of Death (Check only one) 1 ☐ Yes 2 No Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) ER/Outpatient 3 DOA 1 Inpatient 2 I 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28h Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural work? 5 Pending ours after death.

neral Director: Aff
I filled in by the fur 2 Accident
3 Suicide
4 Homicide 2 No Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier (Check 2 Medical Examiner: On the basis of examination are of investigation, it may specify the state of the cause (s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier

5V

Baltimore, Maryland 21215-0036

68760

Box

P.O.

Records,

Division of Vital

State Registrar Date filed (Month, Day, 1ea, MAR 2 6

Registrar
DHMH 17 Rev 7/2009

MD.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Pansariva

March

349 Malcolm Dr Westminster MD 21157

19,2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State	of Maryland		irtment of H tificate of D		Mental Hygier	0010	00239	
			Registrar 1. Decedent's Name (First, Middle, Last)			illicate of B	Catri	Reg. 2. Date of Death	2011	3. Time of Death	
	Physicia Medic	al	Shirlee	М.	В	ialczak		March 2	2, 2012 Year	9:40 A™	
pro- B.	Examin		4a. Facility Name (if not institution, give street and nu			4b. City, Town, or I		4c. County of Death			
بمريد			Gilchrist of Howard C	Ounty 7. Age (In yrs. las	st hirthday)	Columb	ola If Under 24 Hrs.	8. Date of Birth	Howard	nplace (State or Foreign	
	Funeral Director		212-30-8602 1 □ M 2 🗓 F		Yrs.	Months Days	Hours Min.	(Month, Day, Yea	r) Cou	intry)	
	MO I		Usual Residence of Decedent	77				April 15	,1934 M	aryland 10d. Inside City Limits	
	ryland I-f shi	ctol			Town or Loc					1 Yes 2 No	
	or 28¢	Dire	Maryland Baltimore 10e. Street and Number		uther	10f. Zip Code		10a.	Citizen of What Cou		
	with th	eral	146 Warwick Drive			2109)3		U.S.A.	,	
	death items ier mi	by Funeral Director	11 Marital Status 12. Was Dec	cedent Ever in U.S.	13. V	Vas Decedent of His Yes, specify Cuban		ecify Yes or No-	14. Race - Amer		
36	s filed within 72 hours after death with the Maryland tal Hygiene. ad other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by	Mr If Yes, G			☐ Yes 2 X No		riidan, oto.j	Black, White		
8	atura cal E	Completed	3 ☑ Widowed 4 ☐ Divorced Year or [Dates.	16a. Deced	ent's Usual Occupa	tion	16h	. Kind of Business/li	ite	
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2	ygien ygien her th	an l	12			<u>Homemaker</u>			Own Ho	me	
and	be filed ental Hy ked oth ic event	To B	17. Father's Name (First, Middle, Last)					e (First, Middle, Maide		1	
Maryland 21215-0036	should be file n and Mental I 7 is marked c raumatic eve		Rudolph G 19a. Informant's Name/Relationship (Type, Print)	<u>entile</u>	19h Mailin	a Address (Street at		larguerite al Route Number, City			
Š			Christopher Bialczak	Son				ıtherville			
ore,	of Her fitem r othe		20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from	20b. Pla	ace of Dispos	sition (Name of			Location - City or		
im	nit. Page 1 and 2 should be artment of Health and Men ortant: If item 27 is marke injury or other traumatic e.		4 Donation 5 Other (Specify)	Men	norial	Valley Place Gardens	3-26		monium	Maryland	
Baltimore,	permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other once.		21. Signatur f Francia Service Licensee		22	Name and Address 1050 York	s of Facility Ru Road	ck Towson Towson, Ma	Funeral Haryland 2	Home, Inc. 21204	
T			23a. Part T. Enter the disease, or complications that shock, or heart failure. List only one cause on e	caused the death	. Do not ente	r the mode of dying	, such as cardiac	or respiratory arrest,		Approximate Interval Between	
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me.	Medical Examiner		resulting in death) Due to	(or as a conseque	ence of):	70 11 1 711	16 000	nowary.	A . / S . Wales		
		ner	if any, leading to immediate Due to	(or as a conseque	ence of):	Rucin	e Face	now stry	0152452	UZ-AFS	
	uted Id ransit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c.								
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0.	t the c	Phy	g Unknown g Unknown Part II. Other significant conditions contributing to		Iting in the u	adorlying cause give	on in Part I	03a Did tabasa	to use contribute to	the course of death?	
Division of Vital Records, P.O.	ires that signed	Completed by	DEMENTIA	death but not resu	iting in the di	Tuestying cause give	Siriiri dici.			obably 4 Unknown	
ord	w requ	plete	CORONARY ARTERY L	USEASE				24a. Was an autopsy		opsy findings available ompletion of cause of	
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tal	cian: ertific ector,	Be	25. Was case referred to medical examiner?			26. Pla	ce of Death (Chec	k only one)			
Ž	Physic this caral dir	<u>ان</u>	T Yes 2 NO	Inpatient 2 E	R/Outpatien 28b. Time of	t 3 DOA 28c. Injury	4 U Nursing Ho	ome 5 Residence 28d. Describe how in		W HOSPICE	
on c	nding ath. :: Afte ie fune	icate	1 Natural 5 ☐ Pending (Mo 2 ☐ Accident Investigation	nth, Day, Year)	injury	work?			,,		
ivisio	or Atte after des Director in by th	Certificate:		e of Injury - At honding, etc. (Specify)	ne, farm, stre	et, factory, office		28f. Location (Street City or Town, Sta		al Route Number,	
۵	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier (Check (Check 2 Medical Examiner: On the b								
	the H thin 24 the Fi	Me	(Check 2 Medical Examiner: On the bound only one) 3 Certifying Nurse Practitions 29b, Signature and title of certifier				e time, date and pl	ace, and due to the car	use(s) and manner as	stated.	
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	10.1		30. Name and address of person who completed car	use of death (Item :	23a) (Type, P	u!==4\			ARCH 22		
	101		OANIEUE DOBERMAN 31. Date filed (Month, Day, Year) 32.	mo 6	334	LEDAR.	LANE C	OLUMBIA	4, MD 2	1044	
	Sta Registra		MAR 2 6 2012	egistrar's Signatu	1. Be	arkel					

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arlton Briscoe		State of Maryland / Department of Health and Mental Hygiene 20 2 1924 1-For State Certificate of Death Reg. No.
Physicia Medical Examin	ın/	1. Decedent's Name (First, Middle,Last) 2. Date of Death Month Day Year
neulcal Exami		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death
,		Prince Georges Hospital Center Cheverly Prince George's
Funeral Director		5. Social Security Number 219-68-7853 7. Age (In yrs. last birthday) 56 Yrs. 7. Age (In yrs. last birthday) 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign Country) New York
80y		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits
È	ь	DC 1 Yes 2 No
with the Maryland ms 23a or 28a-f sho be notified at once	Director	10e. Street and Number 5000 Nannie Helen Burroughs Avenue 10f. Zip Code 20019 10g. Citizen of What Country? USA
r death or ite	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 1 Never Married 2 Married 2 Married 3 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc.
5-0036 led within 72 hours after Hygiene. to ther than "natural", the Medical Examiner.	ğ	3 \(\begin{align*} \text{Widowed} & 4 \text{Divorced} & \text{If Yes, Give Year} & 1 \text{Yes} & 2 \text{Y} & No \text{specify:} & Specify: \text{Specify:} & \text{black} \\ \end{align*} \] 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done) 16b. Kind of Business/Industry 16b. Kin
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21215-0036 Juld be filed within 7 Mental Hygiene. marked other than ic evec, the Medica	Be C	17. Father's Name (First, Middle, Last) unk
Baltimore, MD 2121 permit. Pages I and 2 should be fi Department of Health and Mental I Important: If item 27 is marked injury or other traumatic eveot,		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Green Door Community Mental Health Agency 1221 Taylor St NW: Washington, DC 20011
Baltimore, permit. Pages 1 and Department of Heal Important: If iten		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State
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Dept Inju		655 W. Baltimore St; Baltimore, MD 21201
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P.O. Box 6876 that the death certificate ned by the attenting phy detached for use as the I	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year 5 Other (Specify)
BOY e death the atte	hysi	1 Yes 2 No 9 Unknown g Unknown
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Division of Vital Records, rai or Atteodiog Physiciae: The law requir rs after death. al Director: After this certificate has been sted in by the funeral director, page 2 should lead in by the funeral director.	Certification:	28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City or Town State) 5,000 Normal of Hollon
Divisi To the Hospital or At within 24 hours after d To the Funeral Direct		4 Homicide Residence/Scene Burroughs Ave. Washington.DC.
o the H ithin 24 o the Fo	Medical	293. Certifier (Check only one) 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
F 3 F 3	ž	29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)
		O.C.M.E. March 10, 2012
		30. Name and address of person who completed cause of death (Item 23a) Jack Titus MD. Deputy Chief Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223
	ate	31. Date filed (Month, Day, Year) 32 (legistrar's Signature MAR 2 6 2012
Regist		
DHMH 17 Rev 1/20	JU 1	ORIGINAL OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 [] 2 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ March 2012 2:30 Рм Donald Webb Bost Jr. Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 4706 Moravia Rd. Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** March 3, Year 1960 Maryland Director 219-78-0058 52 1 X M 2 🗆 F Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Director notified 1X Yes 2 No MD Baltimore 10e. Street and Number 10f. Zip Code ö 10g. Citizen of What Country? must be 21206 USA 4706 Moravia Road items 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 XNo 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ö δ 1 Never Married 2 XMarried Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates white 1 ☐ Yes 2 X No Specify. "natural", 3 Widowed 4 Divorced Completed Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) er than Elementary/Secondary (0-12) College (1-4 or 5+) law enforcement police officer Department of Health and Mental Hygie Important: If item 27 is marked other any injury or other traumatic event, the once. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Margaret Rhoades Donald Webb Bost Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4706 Moravia Road; Baltimore, MD 21206 19a. Informant's Name/Relationship (Type, Print) Sandra Bost = wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, 4 X Donation 5 Other (Specify) Prector Rona I d 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore St; Baltimore, MD 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Ph_sician/ MYOCOMOUN MUUTES disease or condition Medical resulting in death) Examiner TEVMS CUNDNMIT mami Dequentiary list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or injury that initiated events the Hospital or Attending Physician: The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 the use as IF FEMALE: attending 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months? Day Month Vear 1 ☐ Yes 2 ☐ 9 ☐ Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u></u> TA DIMOTES MELLIMS 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed LEND SOME NAME DISTANCE 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page 2 autopsy performe 2 🗌 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ျှ 1 🗌 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After a completely filled in by the funeral 1 Natural 5 Pending work?
1 Yes 2 No Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 215/35 MARCIO 20, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NEWBURE 1. SCOTT MD 5WI COLLY AMEN SWD BATMAN, MD 21234 31. Date filed (Month, Day, Year) **NAR 2 6 2012**

DHMH 17 Rev 06-2011

State Registrar Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of N	Maryland / Depa <i>Cer</i>	artment of H tificate of D			ene 2 0	12 0924	2
	Physicia Medic	_	1. Decedent's Name (First, Mi	ddle, Last)	BROWN			2. Date of Death Month MARCH		Year 945 AM	
	Examin Funeral	Ш	4a. Facility Name (if not instituted to the fact of th	6. Sex 7.7	Age (In yrs. last birthday)	BALT If Under 1 Year Months Days	MORE If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	4c. County o	9. Birthplace (State or Foreign Country)	7
	Director a-t show lied at	ector	Usual Residence of Deceder 10a. State 10b. Cou	nt inty	49 Yrs.	eation		03/25/		Maryland 10d. Inside City Limits 1 Yes 2 No	
	th with the Mims 23a or 28 must be noti	Funeral Director	10e. Street and Number 525 Cherry			Baltimo	5		0g. Citizen of Wh	hat Country?	
9800-	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hyglene, item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	Completed by Fu	11. Marital Status 1 Never Married 2 X 3 Widowed 4 Divor	15 Ven Cine	3? □ No 1	Vas Decedent of His Yes, specify Cuban ☐ Yes 2X No	Specify:	Rican, etc.)	Black Specify:	- American Indian, , White, etc.	
121215-0036	id within 72 h Hyglene, ther than "ns nt, the Medis	Be Comple		ighest grade completed) 2 College (1-4 o years)	(Give k	ent's Usual Occupa ind of work done du NOT use retired) Truck	uring most of work Driver	ing		Employed	
Maryland	nould be file and Mental F s marked of umatic ever	To B	Aaron Brown 19a. Informant's Name/Relation	ı	19b. Mailin	g Address (Street a	Carrie	e (First, Middle, M Crocket al Route Number, (t	ate, Zip Code)	T
	ge 1 and 2 sl nt of Health a it fitem 27 is or other tra			ion 3 Removal from Sta	20b. Place of Dispos cemetery, crem	atory or other place	9)	Date	20c. Location - C	Dity or Town, State	
Baltimore,	permit. Page 1 Department of Important: If it any injury or o		4 ☐ Donation 5 ☐ Oth 21. Signature of Fundal Servi	\sim	on-site	OSEB Addring	of FBTOwn	Jr. Fu	neral	Home PA	_
	Physician/		Immediate Cause (Final dîsease or condition	ist only one cause on each I	ine. TASTATIC	7/3mm		or respiratory arres		Approximate Interval Between Onset and Death	
094	Medical Examiner bhysician and sthe burial-transit	edical Examiner	resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. SP(A) Due to (or a)	is a consequence of): I AL CORT IS a consequence of):		fr e ssi				
Box 687	th certifi ttending for use a	₹	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		n 2 ☐ Fetal death 3 ☐ t at time of death 5 ☐	Ectopic pregnancy Other (specify)	,		23d. Date Mont	of delivery th Day Year	
ords, P.O.	requires that the dee been signed by the a should be detached	by	Part II. Other significant c on	ditions contributing to death	but not resulting in the u	nderlying cause give	en in Part I.		s 2 No 3	oute to the cause of death? B Probably 4 Unknown Dere autopsy findings available	١
of Vital Records,	ician: The law certificate has rector, page 2 s	Be Completed	25. Was case referred to medi	cal		26. Pla	ce of Death (Chec	autopsy perform 1 \square Yes 2	y pri ned2 de	for to completion of cause of eath?	
on of Vita	nding Physicia ath. "After this cert e funeral direct	유	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pe 2 Accident Inv	28a. Date of in		t 3 DOA Other	4 Nursing Ho	ome 5 Resider 28d. Describe how			
Division	ital or Attendi urs after death ral Director; A illed in by the f	al Certificate:	3 Suicide 6 Co	uld not be ermined 28e. Place of I building,	nĵury - At home, farm, stre etc. (Specify)	,		City or Town,	State)	or Rural Route Number,	
	To the Hospital or A within 24 hours after To the Funeral Director Completely filled in b	Medical	(Check 2 Medic	ying Nurse Practitioner: To	f examination and/or invest	igation, în my opinior	n, death occurred a e time, date and pl	t the time, date and ace, and due to the	l place, and due t cause(s) and ma	to the cause(s) and manner state	ed.
			30. Name and address of pers	and be	f death (Item 23a) (Type, P		0001	1	3/15	12012	
	Stat	te ar	DSLAMIAT 31. Date filed (Month, Day, Yea NAR 2 6 20	OLARI BI ar) 32. Regis		1 S- HA	NOVER	ST. BA	-TIMOR	E,MD 21225	

DHMH 17 Rev 06-2011

Thomas Charles Cincotta State of Maryland / Department of Health and Mental Hygiene 2012 09243 Certificate of Death Reg. No. Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ 3. Time of Death Medical Examiner 0942 hrs Thomas Charles Cincotta March 17, 2012 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 52A North Main Street Smithsburg Washington 5. Social Security Number If Under 1 Year 8. Date of Birth (MM/DD/YYYY 9. Birthplace (State or 6. Sex 7. Age (In yrs, last birthday) If Under 24Hrs. **Funeral** Foreign Country)New York Months Davs Hours Min. Director 1 X M 49 1962 127-42-0473 2 F July 13, Usual Residence of Decedent any 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits narked other than "natural", or items 23s or 28s-f show event, the Victical Kromingr must be notified at once, 1 Yes 2 X No Baltimore, MD 21215-0036
pemit. Pages I and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 77 is marked other than "natural", or items 23a or 28a-f sho
injury or other traumatic event, the Metical Examiner must be notified at once. Maryland Washington Smithsburg Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 52 A North Main Street 21783 United States Funeral 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Armed Forces? White, etc. 1 Never Married 2 Married 2 X No Yes 4 X Divorced 3 Widowed If Yes. Give Year Yes 2 X No specify: Specify: White Ś 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry pleted during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Information Technology Services Network Engineer Com 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Joseph John Cincotta Elaine Margaret Beck 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jay Cincotta/Brother 13808 Holly Crest Lane, Dayton, Maryland 21036 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State St. Louis Catholic March 24, Church Cemetery 2012 4 Donation 5 Other Specify. Clarksville, MD 21. Signature of Funeral Service Licen 22. Name and Address of Facility
Donaldson Funeral Home & Crematory, P.A.
1411 Annapolis Road, Odenton, Maryland 21113 Will Etow M00672 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Approximate Interval Between Onset and failure. List only one cause on each line /Medical Death a. Asphyxia Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or es e consequence of); b. Hanging Sequentially list conditions. if any, leading to immediate Due to (or as a consequence of): Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last the attending physician and led for use as the burial - transit siclan/Medical UNPENDED **AMENDED** Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 2 Fetal death 3 Ectopic pregnancy Day Year past 12 months? Pregnant at time of death 5 1 Yes 2 No 9 Unknown icate has been signed by the att page 2 should be detached for Unknown Phy Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, P.O. 至 1 Yes 2 ✓ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of certificate has performe Yes 2 V No 1 Yes 2 No Division of Vital Re
To the Hospital or Attending Physician: Th
within 24 hours after death.
To the Funeral Director: After this certifical
completely filled in by the funeral director, pa 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 🗹 Other: Scene 1 Yes 28a. Date of Injury (Month, Day,Year) FOUND: 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: Subject hanged self 1 Natural FOUND: 1 Yes 2 ✔ No 5 Pending Mar 17, 2012 0910 hrs 2 ___ Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 🗸 Suicide Could not be or Town, State) 52A North Main Street, Smithsburg, MD determined (Specify) Residence 4 ___ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Cal 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. March 18, 2012 30. Name and address of person who completed cause of death (Item 23a) Melissa Brassell, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar

ORIGINAL

DHMH 17 Rev 1/2001 OCME 2006 OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 2011 1700 ULLA DANIEL Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** HOWARD COUNTY GENERAL HOSPITAL OLUMBI 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min (Month, Day, Year) 592-49-2220 91 **Director** 1 🗆 M 2 🗶 F Nov 1, 1920 Haiti Usual Residence of Deceden 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits notified at Director Columbia MD Howard 1 Yes 2 X No 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? er than "natural", or items 23a or the Medical Examiner must be 21045 Funeral 5866 Stevens Forest Rd. Apt 3 USA permit. Page 1 and 2 should be filed within 72 hours after death bepartment of Health and Mental Hygiene.
Important If item 27 is marked other any injury or other the state of the state o 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 X No If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 ☐XNo Specify: black If Yes, Give Year or Dates 3 X Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) domestic College (1-4 or 5+) homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည Degrace Joseph J. Jonassaint 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5866 Stevens Forest Rd., Apt 3, Columbia, MD 21045 Julie Daniel (daughter) 20a. Method of Disposition

1 ABurial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Lake View Memorial 3-30-12 Sykesville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Haight Funeral Home & Chapel Prigreglanger gerber P.O. Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician HEART ONGESTIVE disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner IABETES Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Due to (or de à concaquence of): Exami use as the burial-transi Cause (Disease or injury and that initiated events resulting in death) Last Due to (or as a consequence of): attending physiciar Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 menths?
1 Yes 2 No Day Month Year Pregnant at time of death Other (specify) signed by the all g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available 24a, Was an prior to completion of cause of death?

1 Yes 2 No autopsy has this certificate 1 Yes 2 No 25. Was case referred to medical examiner? within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, Be (26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 2 No 1 Tes 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred iniury 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6
Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated, Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 only one 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 06-2011

5755

CM 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

Registrar's Signature

CHAEL

31. Date filed (Month, Day, Year)

3

21

MAR

Cedar LANE Columbia, MD

2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Lillian P. Dawson March 19 5:45p Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death

Carroll 4b. City, Town, or Location of Death **Examiner** Carroll Hospital Center Westminster . Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Hours 379-16-1986 1 🗆 M 2 🗓 F 88 March 30 1923 VA 10a State 10b. Count 10c. City, Town or Location 10d. Inside City Limits Director MD Carroll Sykesville 1 Yes 2 X No 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code Funeral 21784 Drive 7506 Patapsco 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: white 3 X Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) education teacher Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ٩ Nellie Saunders Ernest Bryant 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7506 Patapsco Dr., Sykesville, MD 21784 19a. Informant's Name/Relationship (Type, Print) Mrs. Joan Hipsley (daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Springfield Cemetery | 3-23-12 Sykesville, MD Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facilit Haight Funeral Home & Chapel ▶ Barge Harget o P.O. Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death ardiac disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Medical Certificate: To Be Completed

physician and as the burial-trans Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 attending p signed by the at d be detached f certificate has be lirector, page 2 s funeral director, 24 hours after death. Funeral Director: A

Funeral

Director

28a-f show

notified at

ms 23a or must be r

permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: I iftem 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu

Department of Important: If it any injury or o once.

Physician/

Medical

Examiner

Baltimore, Maryland 21215-0036

the Maryland

DML				24a. Was an autopsy performed	No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No
25. Was case referred to medical examiner?			26. Place of Death (Che		T L Yes Z No
1 Yes 2 No	Hospital: 1 Inpatient 2 I	ER/Outpatient 3	DOA Other: 4 Nursing I	Home 5 ☐ Residence 6 ☐	Other (Specify)
27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation		28b. Time of injury	28c. Injury at work? 1 Yes 2 No	28d. Describe how injury or	ccurred
3 Suicide 6 Could not 4 Homicide determined	28e Place of Injury - At he		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
200 Cortifier 1 Cortifuing Phy	uninion. To the best of my know	ladge dooth occurred	Let the time, date and place	and due to the sause(s) and	manner as stated

only one 29b. Signatu

2 Gertifying Nurse Practitioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 29d. Date signed (Month, Day, Year)

Manchester

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

00

(Check

32. Registrar's Signature

State Registrar

within 24 hor To the Fune completely f

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State of Marylan		artment of Ho rtificate of D		Mental Hy		CU16	09246
			Registrar 1. Decedent's Name (First, Middle, Las	st)		Timeate of D	Catri	2. Date of De	Reg. No		3. Time of Death
F	Physicia Medic		Xuan Thi Dao					Month March	Da 2		2 11:58 AM
٠, ١	Examin		4a. Facility Name (if not institution, give	·		4b. City, Town, or L	ocation of Dea	th	4c.	County of Deat	th
	uneral	-	Holy Cross Hospi 5. Social Security Number 6. Se		st birthday)	Silver Sp	ring If Under 24 Hr		rth	ontgomes	thplace (State or Foreign
	irector			□ M 2 🔀 F	76 Yrs.	Months Days	Hours Mir	n. (Month, D	ay, Year)	Co	untry)
pg.	how	٦	Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Lo	cation		Dec.31	, 1933	Viet	10d. Inside City Limits
farylar	3a-f s tified	ecto	Thu Duc n/a	To H							1 ☐ Yes ※※ No
the M	or 28	ğ	10e. Street and Number	ттр л	CIII	10f. Zip Code			10g. Cit	izen of What Co	ountry?
h with	ns 23a nust l	Funeral Director	454/1 Tinh Lo 43,			n/a			Viet	nam	
Naryland 21215-0036 should be filed within 72 hours after death with the Maryland	of anyylenic other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates.		Was Decedent of His If Yes, specify Cuban 1 ☐ Yes 2 🛣 No	, Mexican, Puei			14. Race - Ame Black, Whit Specify: As	
5-6	"natu edical	Completed	15. Decedent's E (Specify only highest gra	ducation ade completed)	(Give	dent's Usual Occupat kind of work done du		orking	16b. K	ind of Business	/Industry
ithin 7	r than	Con	Elementary/Secondary (0-12)	College (1-4 or 5+)	life. D Homen	naker			0.00	n Home	
Miled w	othe vent,	Be	17. Father's Name (First, Middle, Last)		***************************************		18. Mother's Na	ame (First, Middle	•		
Yang lid be	arkec	입	unknown				unknowr	1			
Maryland 2 should be filed	if item 27 is marke or other traumatic		19a. Informant's Name/Relationship (7)		T	ng Address (Street ar					o Code)
and and	item 2		Hien Do 20a. Method of Disposition	/Son	lace of Dispo	Laurel Ri	1	Date Date		0 20707 ocation - City or	Town, State
Saitimore, permit. Page 1 and	tant		1 ☐ Burial 2 ☐ Cremation 3 X 4 ☐ Donation 5 ☐ Other (Specifical Service License)	PH)	T Gil	matory or other place,	n APR	314 7, 2012	KHU	PHOTA	MHA S.H.CH.
Der Der	Impo any ir		1 Ken Stiles	M01053	3	2. Name and Address	t Ave.,	naldson Laurel	Fune MD	eral Hom 20707	ne, P.A.
1184410			23a. Part 1. Enter the disease, or comp shock, or heart failure. List only o Immediate Cause (Final	olications that caused the death ne cause on each line.	n. Do not ente	er the mode of dying,	, such as cardia	c or respiratory a	rrest,		Approximate Interval Between Onset and Death
	lician/ ledical		disease or condition resulting in death)	a. Shock Due to (or as a consequ	ence of):						
Exa	aminer		Sequentially list conditions,	_ Cardio enic							
מי	sit	nine	if any, leading to immediate cause. Enter Underlying	Due to (or as a consequ	ence of):					8	
ecute	and Il-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Sepsis Due to (or as a consequ	ence of):				<u>-</u>		
bU ate be executed	physician and s the burial-transit	edical		d							
8/60 ificate b	ig phy as the	Medi	IF FEMALE:	v							
DIVISION OF VITAI RECORDS, P.O. BOX 08/ To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death	ed by the attending detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregna 1 Live Birth 2 Feta 4 Pregnant at time of d 9 Unknown	Ideath 3	Ectopic pregnancy Other (specify)			23d. Date of delivery Month Day Year		
that the	ned by e deta	by Pi	Part II. Other significant conditions co	ontributing to death but not res	ulting in the u	underlying cause give	n in Part I.	23e. Did	tobacco u	se contribute to	the cause of death?
dS, quires	en sig ould b		Multiorgan failu	re				. 1 🗆	Yes 2	□ No 3□P	robably 4 Wunknown
VITAL KECOFOS, ysician: The law requires	To the Funeral Director, After this certificate has been signed isompletely filled in by the funeral director, page 2 should be de-	Completed	Severe multivess	el coronary ar	tery d	lisease				prior to death?	topsy findings available completion of cause of
cian;	sertific ector,	Be	25. Was case referred to medical examiner?	Hospital:		26. Plac	ce of Death (Ch	eck only one)			
OT VI	r this or	<u>ن</u> 10	1 ☐ Yes 2 X No 27. Manner of Death	1 X Inpatient 2 L	ER/Outpatier 28b. Time of	nt 3 🗆 DOA	4 U Nursing	Home 5 Res			ify)
on C Inding	r; Afte	icate	1XXNatural 5 ☐ Pending 2 ☐ AccidentInvestigation	(Month, Day, Year)	injury	work?	es 2 No	204. 20001150	now injury	y oodan od	
DIVISION tal or Attending after death	al Directo	l Certificate:	3 Suicide 6 Could not b 4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify,	me, farm, str	eet, factory, office		28f. Location (City or To			ral Route Number,
he Hospit	he Funer pletely fill	Medical	(Check 2 Medical Exami	sician: To the best of my knowl iner: On the basis of examination se Practitioner: To the best of m	and/or inves	tigation, in my opinion	, death occurred	d at the time, date	and place	, and due to the	cause(s) and manner stated.
To th	To th		29b. Signature and title of certifier			29c. License r	number		29d. Dat	te signed (Montl	n, Day, Year)
			Salv	2—		D64100			Marc	h 21, 2	012
~			30. Name and address of person who of Bhikkaji Smitha,	MD , 1500 For	est Gl		Silver	Spring,	MD 2	0910	
	Stat Registra		31. Date filed (Moñth, Däÿ, Year) NAR 2 6 2012	Begistrar's Signat	park	Yed .					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 2012 0921									09247			
Physician/			1. Decedent's Name (First, Middle, Last) Awad Dindiyal						Month Day Year		3. Time of Death 06:46 A M	
	Medic Examin	_	4a. Facility Name (if not institution, give si		4b. City, Town, or Location of Deat			4c. County of Deat				
	LAGITITI	.	Anne Arundel Medic			Annapol		İs	P		Anne Arundel	
	Funeral				n yrs. last birthday)		If Under 24 Hrs Hours Min	8. Date of Bi		9. Birthplace (State or F Country)		
Ĭ,	Director		579-80-5241 1 X Usual Residence of Decedent] M 2 □ F	65 Yrs.				7, 1947		Guyana	
	nd how at	Funeral Director	10a. State 10b. County	1	Oc. City, Town or Lo-	cation					10d. Inside City Limits	
	faryla Ba-f s		Maryland Montgomery Silver Spring 1 ☐ Yes 2 🕅							1 ☐ Yes 2 🌠 No		
	1 and 2 should be filed within 72 hours after death with the Maryland of Heatit and Mental Hygiene. The teatit and Mental Hygiene. The marked other than "natural", or items 23a or 28a-f show there I marked other than "natural" or items 2 and other traumatic event, the Medical Examiner must be notified at		10e. Street and Number	, ,		10f. Zip Code			10g. Citizen	of What Cou	intry?	
		era	900 Bay Hill Lane				20905		Ur	nited	States	
	death item ner n		11. Martar States	 Was Decedent Even Armed Forces? 		Was Decedent of Hi f Yes, specify Cuba	spanic Origin? (\$ n, Mexican, Puer	Specify Yes or No to Rican, etc.)		Race - Ameri Black, White,		
0000	after al", or xami	d b	1 ☐ Never Married 2 🏋 Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 X No If Yes, Give Year or Dates.		1 ☐ Yes 2 🏋 No	Specify:		Spe	cify: Asi	an Indian	
2	hours natura ical E	To Be Completed	15. Decedent's Edu	ucation	16a. Deced	dent's Usual Occupa	ation		16b. Kind o	f Business/Ir	ndustry	
N .	n 72 e. ian "r Med		(Specify only highest grad	life D	(Give kind of work done during most of work life. DO NOT use retired)			Non-Profit				
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Ž	d Mer mark matic		Dindiyal 19a. Informant's Name/Relationship (Typ	o Drint)			Mania I		or City or Tour	- Ctata Zin	Cadal	
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baitimore,	permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other 1 once.		21. Signature of Funeral Service License	e /	22	2. Name and Address	s of Facility Funeral	Home &	Cremat	orv.	P.A.	
٠			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate							Approximate		
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	Examiner	<u>.</u>	Sequentially list conditions,							もっくと		
	sit s	edical Examiner	Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence CALRE OUT TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO BE TO								DAZI	
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ě	The la	Con	, 						ormed? 2 No	death?	2 🗆 No	
VITal	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Be	25. Was case referred to medical examiner?	lospital:		26. Pla	ace of Death (Ch	eck only one)	_			
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DIVISION OF		Certificate:	1 Natural 5 Pending (Month, Day, Year) 2 Naccident Investigation			28b. Time of 28c. Injury at work? M 1 \sum Yes 2 \sum No			28d. Describe how injury occurred			
20	Atten	ırtifi	3 Suicide 8 Could not be 28e. Place of Injury - At h			ome, farm, street, factory, office			28f. Location (Street and Number or Rural Route Number,			
2	re Hospital or , n 24 hours afte te Funeral Dire oletely filled in bietely filled in filled in filled in filled in filled in filled in filled in filled in filled in filled in filled in filled in filled in filled in filled in filled in filled in filled in filled in filled in filled in filled in filled in filled in filled in filled in filled in filled in filled in filled in filled in filled in filled in filled in filled in filled in filled in filled in filled in filled in filled in filled in filled in filled in filled in filled in filled in filled in filled in filled in filled in filled in filled in filled in filled in filled in filled in filled in filled in filled in filled in filled in filled in filled in filled in filled in filled in filled in filled in filled in filled in filled in filled in filled in filled in filled in filled in filled in filled in filled in filled in filled in filled in filled in filled in filled in filled in filled in filled in filled in filled in filled in filled in filled in filled in filled in filled in filled in filled in filled in filled in filled in filled in filled in filled in filled in filled in filled in filled in filled in filled in filled in filled in filled in filled in filled in filled in filled in filled in filled in filled in filled in filled in filled in filled in filled in filled in filled in filled in filled in filled in filled in filled in filled in filled in filled in filled in filled in filled in filled in filled in filled in filled in filled in filled in filled in filled in filled in filled in filled in filled in filled in filled in filled in filled in filled in filled in filled in filled in filled in filled in filled in filled in filled in filled in filled in filled in filled in filled in filled in filled in filled in filled in filled in filled in filled in filled in filled in filled in filled in filled in filled in filled in filled in filled in filled in filled in filled in filled in filled in filled in filled in filled in filled in filled in filled in filled in f		building, etc. (Specify)					City or Town, State)				
		Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
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i	0 1		30. Name and address of person who co		th (Item 23a) (Type, I		nanolis	Marvler	nd 2140	1		
	Stat	e	31. Date filed (Month, Day, Year) MAR 2 6 201		s Signa are		-aporro,	iidi y idi	2170	<u>*</u>		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ MARCH 22, 2012^{ea} 5:15 PM LEAH DIAS Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death KESWICK MULTI-CARE CENTER N/A BALTIMORE Social Security Number If Under 1 Year If Under 24 Hrs Age (In yrs. last birthday, 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛚 Months Hours Country) 77 0570371934 218-58-5943 INDIA Director Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits must be notified at Director 1x Yes 2 ☐ No MD N/A BALTIMORE 10e, Street and Number 10f. Zip Code ö 10g. Citizen of What Country? by Funeral 23a 2500 W. BELVEDERE AVENUE, #1103 21215 USA or items and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, event, the Medical Examiner Armed Forces?
1 ☐ Yes 2 🖺 No Black White etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes Give 3 Widowed 4 Divorced "natural", Completed INDIAN Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 8 HOMEMAKER OWN HOME Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental I ျှ UNKNOWN SAMSON SUSAN BENJAMIN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 M. ISABELLE MACGREGOR/PHYSICIAN 700 W. 40TH STREET, BALTIMORE, MD 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or otl XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) BALTIMORE HEBREW CEM 03/23/2012 BALTIMORE, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or pear failure. List only one cause on each line. Immediate Cause (Final disease or condition Onset and Death Physician/ dieny bahnews Medical resulting in death) Examiner Sh diseas wherever Sequentially list conditions, Examine Due to (or se a consequence of): if any, leading to immedicause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last and Due to (or as a consequence of): led by the attending physician detached for use as the burial Physician/Medical P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Yes 2 - No 1 Urknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? 1 Yes 2 No 25. Was case referred to medica Certificate: To Be 26. Place of Death (Check only one) examiner? 2 1 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA in by the funeral 27. Mann f Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred After t 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No after death Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours at To the Funeral D completed filled in Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year)





31. Date filed (Month, Day, Year)
NAR 2 6 2012

DAGREGOR, 700 W to th STREET, BALTITORE, 97) 21211

an 32. Registry's Signature

Charles S. Salles

30. Name and address of person who completed cause of death (item 23a) (Type, Print)

013657

Tweeh 23.2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 20T2 March 9:40 Rita J. Egnet Рм Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Frederick Memorial Hospital Frederick Frederick 6. Sex Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country)
 M A **Funeral** Days Feb. 26, Year 1938 1 - M 2 X F Hours MA 027-28-3517 74 **Director** Usual Residence of Decedent 28a-f shov 10a. State 10b. County with the Maryland 10c. City, Town or Location 10d. Inside City Limits notified at Director 1 Yes 2X No MD Carro11 Mt. Airy 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? ian "natural", or items 23a or Medical Examiner must be i Funeral 21771 4101 Baltimore National Pike permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items ? any injury or other traumatic event. The Manage 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married δ If Yes, Give Year or Dates 1 ☐ Yes 2X ☐ No Specify: White Specify: Completed 3 X Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 12 College (1-4 or 5+) Assembler Laboratory Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Unknown Frank Dion 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 177 Whispering Echos Dr., Kearneysville, WV 25430 19a. Informant's Name/Relationship (Type, Print) Mrs. Diane Hall (Daughter) Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 🗆 Burial 2 💢 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) All County Cremation 3/26/2012 Sykesville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility HAIGHT FUNERAL HOME & CHAPEL, PA PO Box 195 Sykesville, MD 21784 100764 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between set and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a Examiner NEUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Uncerlying Examine attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical • Hospital or Attending Physician: The law requires that the death certificate be 124 hours after death.
• Funeral Director, After this certificate has been signed by the attending physicis Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year be detached signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 ALZHEIMERS 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 🗆 No 1 Yes funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? ė Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred injury 1 Natural 5 Pending To the Hospital or Attendir within 24 hours after death.

To the Funeral Director, Af completed filled in by the fu 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Cartifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check

State Registrar

only one 29b. Signature and

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print

DHMH 17 Rev 7/2009

29c. License number

026499

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2012 09250 1- State Registrar Certificate of Death Reg. No.										
	Physicia	n/	1. Decedent's Name (First, Middle, Last) Mildred 0.		Freer	2. Date of Death Month 14, Day 2012		3. Time of Death 6:46 P M		
parts.	Medic Examin		4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Loca		iluleii 1	4c. County of E		
· married			Absolute Assisted Living		Rockville			Montgo	omery	
	Funeral Director		5. Social Security Number 195–16–1595 6. Sex 1 □ M 2 ★ F 9	(In yrs. last birthday) 2 Yrs.		Jnder 24 Hrs. ours Min.	8. Date of Birt Nov • 12	h , Yea/1919 B	. Birthplace (State or Foreign fattrord, PA	
	ow t	L	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Loc	nation				10d. Inside City Limits	
	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral Director	Maryland Montgomery	Rockville					1 🖾 Yes 2 🗆 No	
		١	10e. Street and Number		10f. Zip Code			10g. Citizen of Wha	t Country?	
		nera	4911 Brooks Road	·	20853		15 27	U.S.A.		
9		by Fu	11. Marital Status 12. Was Decedent E Armed Forces? 1 Never Married 2 Married 1 Yes 2 X	No.	Vas Decedent of Hispani f Yes, specify Cuban, Me	exican, Puerto I	Rican, etc.)		American Indian, White, etc.	
003		ted	3 X Widowed 4 ☐ Divorced If Yes, Give Year or Dates.	1	Yes 2 🕅 No Sp			Specify:	White	
15-		Completed	15. Decedent's Education (Specify only highest grade completed)	(Give I	tent's Usual Occupation kind of work done during O NOT use retired)	g most of workir	ng	16b. Kind of Busin	ess Industry	
212			Elementary/Seconday (0-12) College (1-4 or 5-	Owne	r/Manager			Retail B	usiness	
Maryland 21215-0036		To Be	17. Father's Name (<i>First, Middle, Last</i>) Floyd Taylor			Mother's Name		Maiden Surname)		
Mary			19a. Informant's Name/Relationship (Type, Print) Michelle Ziafat (Niece)		ng Address (Street and N Brooks Rd.,				e, Zip Code)	
Baltimore,	Page 1 an nent of He int: If iten iry or othe		20a. Method of Disposition 1 ☑ Berrat 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. Place of Dispo cemetery, cren Grimes Ce	natory or other place)		/2012	20c. Location - Cit Port Alle		
Balti	permit. Departn Importa any inju		21. Si nature of uneral Service Lice ee	22	Name and Address of 1517 Vine S	fa ^{cil} funer t., Ale	al Serv xandria	ice VA 2231	10	
	Total		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final							
	Physician Medical		Immediate Cause (Final disease or condition resulting in death) Breast Cancer Due to (or as a consequence of):							
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	ner	Sequentially list conditions, If any leading to initial date Due to for as a consequence off:							
		dical Examiner	cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of):							
09		ical	d							
876		Med	IF FEMALE:	,						
Box 687		Physician/Me	23b. Was decedent pregnant in the past 12 months? 1	2 🗌 Fetal death 3 📙	Ectopic pregnancy Other (specify)			23d. Date o Month		
P.O.		þ	Part II. Other significant conditions contributing to dearn but not resoluting in the discessing cause given in r act.							
rds,		eted							Yes 2X No 3 Probably 4 Unknown s an 24b. Were autopsy findings available	
of Vital Records,		Completed					24a. Was a autop perfo	prior prior deat	r to completion of cause of	
/ital		To Be (25. Was case referred to medical 26. Place of Death (Check only one) Page 15. Was case referred to medical examiner? Debag: The charge of Death (Check only one)							
n of \							ow injury occurred			
Division		Certificate:	2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Inju	eet, factory, office 28f. Locatio			n (Street and Number or Rural Route Number, Town, State)			
1		Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
		2	29b. Signature and title of certifier	- In the mode of the	29c. License num			29d. Date signed (M	fonth, Day, Year)	
			· source	D42518 March 15, 2012						
7			30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Gul Chablani, M.D. 11119 Rockville Pike #401 Rockville, MD 20852							
	Sta Registr		31. Date filed (Month, Day, Year) MAR 2 6 2012	r's Signature			-			

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 3-104 Physician/ MARCH 2012 Teresa Ann Foster Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deat **Examiner** MURNIE KNNE BALTIMORE KLACHINGROW MEDICAL CEN 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday **Funeral** (Month. Day, Year, Hours Min Country 84 Yrs. **Director** 1 🗆 M 2 😿 F July 18, 1927 New York 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location at Director be notified 1 Yes 2x No Ft. George G. Meade Maryland Anne Arundel 10f. Zip Code 10g. Citizen of What Country? ō 10e. Street and Number Funeral 23a must 1 **United States** 20755 4880 Jones Drive items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 14. Race - American Indian. Examiner If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Force Black, White, etc. "natural", or þ 1 Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced Completed permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical. 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) State Government Court Clerk 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ၉ Catherine McCartin Michael Ryan 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4880 Jones Drive, Ft. George G. Meade, MD 20755 Kathy Hachey/Niece 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place.
West Arundel March 25, 1 Burial 2 K Cremation 3 Removal from State Odenton, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2012 Crematory 22. Name and Address of Facility Donaldson Funeral Home & Crematory, P.A., 1411 Annapolis Road, Odenton, Maryland 21113 21. Signature of Funeral Service License M01386 nplications to t caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one can be only ach line. Approximate 23a. Part Interval Between Onset and Death shock, or hea Immediate Cause (Final Physician/ NEUMORIB disease or condition resulting in death) Medical FAILURE **Examiner** LUESTIVE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examin MENTIA -tran and that initiated events Due to (or as a consequence of) resulting in death) Last physician a the burial-Physician/Medical requires that the death certificate be P.O. Box 68760 as attending IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown use 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 Yes 2 No Month Dav the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 No 3 Probably 4 Unknown Division of Vital Records, page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 N this certificate has completely filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 28b. Time of 28d. Describe how injury occurred Certificate: After Hospital or Attending 24 hours after death. 5 Pending 1 Yes 2 No Accident Investigation Funeral Director: Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: It the best of my included about a country of the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 3 — Certifying Nurse Practitioner: To the best of my knowled 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 46149

State Registrar DHMH 17 Rev 06-2011 Name and address of person who competed cause of death (Item 23a) (Type, Print)

MARAL

31. Date filed (Month, Day,

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32. Registrar's Signati

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item State of Maryland / Department of Health and Mental Hygiene 10e per fh,g925,03/21/2012dhb Certificate of Death Reg. No. for State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year 2340 1AR CUERITE Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death OF MARYLAND MEDICAL UNIVERSITY COVIER BALTIMORE Baltimore City Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Min. 212-28-4275 **Director** 1 □ M 2 🔽 F 86 April 21,1925 Maryland Usual Residence of Decedent 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Harford Joppa 1 Tes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Avenue Funeral 21085 Avenuseac USA 1110 Oak 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married ☐ Yes 2 🛣 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☐xNo Specify. Specify Completed 3 X Widowed 4 ☐ Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within 72 th and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) <u>Homemaker</u> Homemaking-Own Home N/A Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Marquerite Belbin Gurney Lindale Godwin 19a. Informant's Name/Relationship (Type, Print) Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1300 Vanderbuilt Rd. Bel Air, Maryland 21014 permit. Page 1 and 2 st Department of Health ar. Important: If item 27 is any injury or any Doris Stevenson (Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2-20-2012 Parkwood Cemeterv <u>Baltimore, Md.</u> 22. Name and Address of Facility ature of Funeral Se Lassahn Funeral Home 7401 Belair Rd. Baltimore, Md. 21236 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ YFOXIA disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner RAUMATIC Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury UEHILLE that initiated events Due to (or as a consequence of): resulting in death) Last burial-ार्टी क्रिक्स किया मार्टी क्रिक्स किया मार्टी अपार्टि किया हिन्दी किया Box 68769 attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 month 1 Yes 2 No Day Pregnant at time of death 1 Yes 2 Unknown Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should peen Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe After this certificate 1 Yes 2 No the Hospital or Attending Physician; 25. Was case referred to medical Be 26. Place of Death (Check only one) examino? 1 Yes 2 No. Hospital Other: 1 Impatient 2 ER/Outpatient 3 DOA P 4 Nursing Home 5 Residence 6 Other (Specify) Director: After this in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☑ No ☐ Natural ☐ Accident injury 5 Pending MOTOR VEMICLE COLLISION Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, determined building, etc. (Specify) at Mill Rach, Abingdon ludelphic Rd 24 hours Medical 29a. Certifier 🚅 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certi 29c. License number EB (6, 2012 and address of person who completed cause of death (Item 23a) (Type, Print) MO 2120 JOSE 5

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day,

MAR 26

Registrar's Signature

32.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day} 2012 Physician/ Month <u>Francis Gilbert Guston</u> March 21 6:57 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 2902 Westfield Avenue Baltimore City 8. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In yrs. last birthday) If Under If Under 24 Hrs 9. Birthplace (State or Foreign **Funeral** Months Hours Min 213-16-5227 **Director** 1 X M 2 - F 90 November 8, 1921 Maryland Usual Residence of Decedent 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State event, the Medical Examiner must be notified at Director 1 ¥ Yes 2 □ No Maryland Baltimore City n/a 10e. Street and Number ō 10g. Citizen of What Country? Funeral items 23a 2902 Westfield Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 2. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. 1 X Yes 2 ☐ No If Yes, Give and Mental Hygiene. 1 Never Married 2 X Married þ 21215-0036 1 ☐ Yes 2 🙀 No Specify: Completed 3 Widowed 4 Divorced Year or Dates. WW II White 16a. Decedent's Usual Occupation (Give kind of work done during most of working 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Engineer U.S. Coast Guard Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Francis Gilbert Guston, Sr. Anna Niedzwiecki 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: If item 27 2902 Westfield Avenue Baltimore, Maryland 21214 Mrs. Helen J. Guston (Spouse) injury or other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🗶 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place, 4 Donation 5 Other (Specify) 3/26/2012 Highview Memorial Fallston, Maryland 22. Name and Address of Facility 21. Signature Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Md. 23a. Part 1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on such line. Approximate Interval Between Immediate Cause (Final Onset and Death Reumonia Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): Cause (Disease of Injury that initiated events resulting in death) Last burial-trar Due to (or as a consequence of): ending physician use as the burial Physician/Medical death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year signed by the a Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy Vital the Hospital or Attending Physician: thin 24 hours after death. the Funeral Director: After this certific moletely filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 2 No 1 🗌 Yes ဂ္ဂ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Division of Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Matural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 24 hou

To the Fune

completely fi (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Gertifying Nurse Practitioner: To the best of my knowledge 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) leted cause of death (Item 23a) (Type, Print) 30. Name and address of person who comp Year)

State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Manyland / Department of Health and Mental Hygiene

ianne Goloboski	State of Maryland 1- For State Registrar	Department of Healt / Department of Deatt	1	eg. No. 2012 0925
Physician/ Medical Examine	Decedent's Name (First, Middle,Last)	oloboski	2. Date of Deal Month March 21,	th 3. Time of Death
	4a. Facility Name (if not institution, give street and number	er) 4b. City, T	own, or Location of Death	4c. County of Death
Funeral	7304 Rocky Creek Drive 5. Social Security Number 6. Sex 7. A	Colun Age (In yrs. last birthday) If Unde		Howard th(MM/DD/YYYY) 9. Birthplace (State or
Director	219-78-1839 1 M 2 X F Usual Residence of Decedent	54 Yrs. Month	Days Hours Min. 12/05/	/1957 Foreign Country)Maryland
w any	10a. State 10b. County	10c. City, Town or Location		10d. Inside City Limits
Maryland 28s-f show d at once.	MD Howard 10e. Street and Number	Columbia 10f. Zip	Code 1	1 Yes 2 No No Og. Citizen of What Country?
ith the Maryland 23a or 28a-f sho notified at once. al Director	7304 Rocky Creek Drive		21046	U.S.A.
r death w or items rust be	11. Marital Status 1 XNever Married 2 Married Armed Force 1 Yes 3 Widowed 4 Divorced If Yes, Give Year	rs? If Yes, specif	nt of Hispanic Origin? (Specify Yes or No Cuban, Mexican, Puerto Rican, etc.) X No specify:	- 14. Race - American Indian, Black, White, etc. Specify: White
ours after all starting to by	15. Decedent's Education (Specify only highest grade of	ompleted) 16a. Decedent's Usual	Occupation (Give kind of work done king life. DO NOT use retired)	16b. Kind of Business/Industry
0 = 2	Elementary/Secondary (0-12) College (1-4 o	or 5+) C.P.A		Owner/Consulting
215-0036 be filed within ntal Hygiene. rked other tha ent, the Medic	17. Father's Name (First, Middle, Last)		18.Mother's Name (First, Middle, I	
21215. Uld be filec Mental Hy marked of c event, th	Theodore James 19a. Informant's Name/Relationship (Type, Print)	Goloboski Sr.	Elaine (Street and Number or Rural Route Num	Dorothy Slater
MD 21215-0036 12 should be filed within 7 th and Mental Hygiene. 127 is marked other than numatic event, the Medical To Be Comple	Mark Goloboski-brother	3900 Goo	se Harbor Rd., Balt	imore, MD 21220
4 2 2 E	20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from	20b. Place of Disposition (Nan crematory or other place)		20c. Location - City or Town, State
Baltimore, permit. Pages 1 a Department of He Important: If its injury or other ti	4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee Willia	Hilltop Servic		Towson, MD on Funeral Home, Inc.
Ba Perm Depr Imp	100	1 1050 Y	ork Rd., Towson, MI	21204
Physician Medical	23a. Part I. Enter the disease, or complications that caus failure. List only one cause on each line. Mixed			est, shock, or heart Lnd Between Onset and Death
Examiner	Immediate Cause (Final disease or condition resulting in death) a.diphenhyo	Iramine) Intoxicat nsequence of):	ion	
P	Sequentially list conditions, if any, leading to immediate b.	nsequence of):		
ted Insit Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a co	nsequence of):		
tO, e be executed ysician and burial - transit	d	a,27,28a-f,per me	σ925 3-29-12 sm	
50, te be execut tysician and burial - tra	IE EENALE: 23c H ves out	come of pregnancy		23d. Date of delivery
b. Box 6876 the death certificate by the attending phy ched for use as the	23b. Was decedent pregnant in the past 12 months?	2 Fetal death	3 Ectopic pregnancy	Month Day Year
Box e death of the atter ed for us	1 Yes 2 No 9 V Unknown 9 Unknown	J Utiler (Spec		
P.O. ss that the gned by e detach		ath but not resulting in the underlying	Saddo giveri ii i aik ii	bbacco use contribute to the cause of death? s 2 ✓ No 3 Probably 4 Unknown
Records, P The law requires is fitcate has been sign i, page 2 should be C Completed k			24a. Was autop	
Division of Vital Records, talor Attending Physician: The law requir rs after death. al Director: After this certificate has been seled in by the funeral director, page 2 should bertification: To Be Completee			perfo 1 ✔ Yes	rmed? death?
ital Recition: The certificate rector, page	25. Was case referred to medical examiner?	atient 2 ER/Outpatient 3 D	26.Place of Death (Check only one) OA Other Nursing Home 5	Pasidance 6 Other Scane
ing Physi After this funeral dir	1 Yes 2 No 27. Manner of Death 28a. Date of I (Month, Da	niury 28b. Time of Injury 2	8c. Injury at Work? 28d. Describe	how injury occurred
sion ttendir death. ctor: A y the fu	Pending Fd 3-2	21-12 fd 9:44 am	drugs	ingested alcohol and
Division ospital or Attending nours after death. meral Director: After filled in by the fune Certification:	3 X Suicide 6 Could not be determined (Specify)	finjury - At home, farm, street, factory found at hom	e 281. Location (some Town, Some Columbs	Street and Number or Rural Route Number, City State) 7304 Rocky Creek Dr.
the Ho nin 24 1 the Fu upletely	29a Certifier	my knowledge, death occurred at the xamination and/or investigation, in my	time, date and place, and due to the caus opinion, death occurred at the time, date	se(s) and manner as stated.
To To with Tour	29b. Signature and title of certifier		License number	29d. Date signed (Month, Day, Year) March 22, 2012
	30. Name and address of person who completed cause of	of death (Item 23a)	O.C.M.E.	Maion ZE, EVIE
Ø	Patricia Aronica-Pollak MD. Assistant	Medical Examiner 900 W	Baltimore Street, Baltimore, M	D 21223
State Registra	MAR 2 6 2019 A	trai's Signature		
DHMH 17 Rev 1/2001	OCME	ORIGINAL		

			Pleas	se Type or Pr							•	
	1	For State		State of N	/larylan		partment of I partificate of I		Mental Hy	•	0010	0 00055
	ŕ	Registrar 1. Decedent's Name	e (First, Middle,	Last)			illicate of L	Jean I	2. Date of De	Reg. No	1000	3. Time of Death
Physician/ Medical		EVELY	IN S.	GREENB	ERG				Month 3	Da	21 Year 17	6:15 P M
Examiner		4a. Facility Name (if	not institution,	give street and number)			4b. City, Town, o	r Location of Death		40	. County of Deat	
				ALLEY WAY	// /			GS MILLS	1001 (0)		BALTI	
Funeral Director		5. Social Security No.	2032	5. Sex 1 □ M 2 🗶 F	.ge (In yrs. 1	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bi	71 ⁷ 934	9. Birt	thplace (State or Foreign untry) MD
and show	-	Usual Residence of 10a. State	10b. County		10c. Cit	y, Town or L	ocation					10d. Inside City Limits
or 28a-f shore notified at		MD	BAL	TIMORE		OWI	NGS MILLS	}				1 ☐ Yes 2 🙀 No
h the sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or sa or		10e. Street and Nun	nber				10f. Zip Code			10g. Ci	tizen of What Co	untry?
be filed within 72 hours after death with the Maryland ental Hygiene. Ked other than "natural", or items 23a or 28a-f sho ic event, the Medical Examiner must be notified at To Be Completed by Funeral Director	-		ELVET V	ALLEY WAY			211				USA	
fter dea		 Marital Status Never Marri 	ied 2 😿 Marrie	12. Was Decedent Armed Forces 1 Yes 2	: Ever in U.S ? [] No	5. 13.	Was Decedent of H If Yes, specify Cuba	lispanic Origin? (Sp an, Mexican, Puerto	ecity Yes or No- Rican, etc.)		 Race - Ame Black, White 	
rs afte rral", Exan		3 🗆 Widowed		If Yes, Give Year or Dates.	110		1 ☐ Yes 2 🗶 No	Specify:			Specify: V	HITE
vithin 72 hours ar iene r r than "natural" the Medical Exa Completed	Ī	(Spe	15. Decedent	's Education t grade completed)			edent's Usual Occup		dna	16b. K	(ind of Business	Industry
thin 7 than than he Me	ŀ	Elementary/Seco		College (1-4 or	5+)	life.	DO NOT use retired) MEMAKER		y		OWN HO	IME
Hygie Other ent, tl	ŀ	17. Father's Name (i	First, Middle, La	st)		110	PIEPIAKEK	18. Mother's Nam	ne (First, Middle	Maiden)ME
lbe fill lental lental rked ricev		ISAAC		•	KESSI	LER		VIRGIN		,		MARKIN
should and M is ma	ľ	19a. Informant's Na	ame/Relationshi	p (Type, Print)		T	ling Address (Street			er, City or	Town, State, Zip	
nd 2 s ealth m 27 ner tra				ENBERG/HUSI	BAND	23	07 VELVET	VALLEY V	WAY, OW	INGS	MILLS,	MD 21117
permit. Page 1 and 2 should be filed within 72 hours after dea Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Examiner once. To Be Completed by Fi	2	20a. Method of Disp 1 X Burial 2		3 ☐ Removal from Stat		Place of Disp emetery, cre	osition (Name of ematory or other plac	ce)	Date	20c. L	ocation - City or	Town, State
it. Pag irtmen irtant: njury	-		5 Other (Sp		BET		MEMORIAL		3/2012		ANDALLST	
permi Depar Impo any ir once.	ľ	21. Signature of Eur	neral Service Lic	ensee			22. Name and Addre 8900 REIS					
	+	23a. Fart 1. Ent of	disease, or o	omplications that cause	ed the deat						3,412,616	Approximate
Physician/	1	Immediate Cause (disease or condition	Final	ly one cause on each li	ne. / T / /	21 E	MYEL	DMA				Interval Between Onset and Death
Medical Examiner	1	resulting in death)	4	a. Due to (or as	s a consequ	uence of):	11/02	7.7				Tyear
	1	Sequentially list co	nditions,	b								
kecuted and al-transit	1	if any, leading to im- cause E to Unon Cause (Disease or	rllylt/g	Due to (or as	s a consequ	ience of):					- 7	
xecut n and al-trar		that initiated events resulting in death) I	S	c. Due to (or as	s a consequ	uence of):						
auth certificate be executed attending physician and for use as the burial-transit cian/Medical Exami	ı			d								
ut the death certificate by by the attending physic stached for use as the b Physician/Medic	ŀ	F FEMALE:										
ath ce	2	23b. Was decedent in the past 121	months?	23c. If yes, outcom 1 Live Birth 4 Pregnant	2 🗌 Feta	al death 3	☐ Ectopic pregnand	су			23d. Date of del Month	ivery Day Year
y the ched	L	1 Yes 2 9 Unknown	LI No	9 Unknown		Jean J						
gned b	. 1	Part II. Other signif	ficant condition	s contributing to death	but not res	ulting in the	underlying cause gi	ven in Part I.	23e. Did	tobacco i	use contribute to	the cause of death?
quires en sig buld by								-	1 🗆	Yes 2	Y No 3 □ Pi	robably 4 🗆 Unknown
The law require cate has been si page 2 should I									24a. Was	psy	prior to d	topsy findings available completion of cause of
cate h									perf 1 ☐ Yes	ormed? 2 N	death?	2 🗆 No
certifi rector	П	25. Was case referre examiner? 1 \sum Yes 2	ed to medical No	Hospital:			Oth	lace of Death (Chec				
g Physi er this c eral dire e: To		27. Manner of Death	h	28a. Date of in	jury	28b. Time		y at	ome 5 PResi 28d. Describe		Other (Speci y occurred	ify)
eath. or: Ath he fu		1 Natural Accident	5 Pending	ation	ay, rear)	injury	M 1 □	Yes 2 No				
r Attending P after death. Director: After t in by the funera Certificate:		3 ☐ Suicide 4 ☐ Homicide	6 ∐ Could ne determin	ed 28e. Place of Ir	jury - At ho tc. <i>(Specify</i>		reet, factory, office		28f. Location (City or To			ral Route Number,
pital burs a eral D filled		29a. Certifier 1	Cortifuing I	Physician: To the best of	of my knowl	edge deeth	occurred at the time	data and place of	ad due to the or	21.00(a) ar	d mannor on eta	tod
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Medical Certificate: To Be Completed by Physician/Medical Exam		(Check 2	Medical Ex	aminer: On the basis of Nurse Practioner: To th	examination	and/or inve	stigation, in my opinio	on, death occurred a	t the time, date	and place	e, and due to the	cause(s) and manner stated
To th within comp		29b. Signature and		1.0			29c. License	e number		29d Da	te signed (Month	n. Dav. Year)
		16	1.00	M				2773	0	M	arch 2	2,2012
10		GARY	COHEN	ho completed cause of	death (Item	23a) (Type, N. (Print) WAKLES	557.	BALTI	YOR	E, no	2,2012
State Registrar	3	31. Date filed (Monti	6 2012	Server 32. Regist	rar's Signe	ure and						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month Physician/ Linda Sue Honevcutt 5:33 26, March 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 317 Londontown Rd. Edgewater Anne Arundel 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 220 62 2380 Director 1 M 2 X 57 Aug. 31, 1954 Maryland ms 23a or 28a-f show must be notified at 10b. Count 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Maryland Anne Arundel Edgewater 1 Yes 2X No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 317 Londontown Rd. 21037 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or item ledical Examiner n 11. Marital Status 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, Black, White, etc. 2 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 within 72 hours after Specify: White If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify 3 Widowed 4 X Divorced Completed d Mental Dysec... marked other than "natural marked other than "natural marked of the Medical" 16a, Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Manager Grocery/ Deli 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname and Mental I John R. Lanasa Mary Middleton 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Ron Honeycutt (Son) 1207 Middleborough Rd.Apt. J Baltimore, Maryland item 27 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State ь permit. Page Department of Important: If any injury or once. Bayview Crematory Inc. 3/27/2012 Baltimore, Maryland 4 Donation 5 Other (Specify) . Signature of Funeral Service Lisenses ^{22. Name and Address of Facility} Bruzdzinski Funeral Home P.A. 1407 Old Fastern Avenue Essex, Maryland 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, effect, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) as the burial-Physician/Medical use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Pregnant at time of death Yes Unknown by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an has 1 ☐ Yes 2 ☑ No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 1 Yes 2 XNo ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 XResidence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: X Natural 5 Pending 1 Yes 2 No Accident
Suicide
Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined

Box 68760 P.O. Records, of Vital or Attending Physician: 24 hours after death. e Funeral Director: Aft Division Hospital To the Hosp within 24 hor To the Fune completely fi

> State Registrar

Medical

29a. Certifier

only one) 29h Signature and title of

DHMH 17 Rev 06-2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

City or Town, State)

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	1	For Ame State Ame Registrar	nd Items	State of 1 25,27,28	Marylan B a-f p	d/Depa er me Cer	artment 2925 tificate	of H 03/2	lealth 1/20 eath	and M 12dh l	1ental H b	ygien Reg. N	e 20	12	09257
Physician/ Medical	/	1. Decedent's Name	(First, Middle, La	st)		-					2. Date of I Month OA	Death		Year	3. Time of Death
Examiner	•	4a. Facility Name <i>(if r</i>	_	^			4b. City, T		Location				Rate	f Death	re.
Funeral Director	1	5. Social Security Nu 218-22-	imber 6.5		Age (In yrs. Ia		If Under	-	If Under Hours		8. Date of E (Month, I				place (State or Foreign
yland f show ed at	1010	Usual Residence of 10a. State	10b, County		1	, Town or Loc									10d. Inside City Limits
th the Maryland 3a or 28a-f sho t be notified at		MD 10e. Street and Num 3110 E1b			1 1	Baltin	10f. Zip	Code 212	220			10g. (Citizen of Wh		1 XYes 2 No
Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once. To Re Completed by Finneral Director		11. Marital Status		12. Was Deceder Armed Forces 1 Yes 2	3?			ent of His	spanic Orig		cify Yes or N Rican, etc.)	D-	14. Race		
21215-0036 Athin 72 hours after tiene. I than "natural", or the Medical Exami	naiai	3 🕅 Widowed 4	Divorced 15. Decedent's i	If Yes, Give Year or Dates Education		16a. Deced	Yes 2					16h	Specify: Kind of Busi		ack
21215-0036 within 72 hours after giene. er than "natural", o, the Medical Exam.		Spec Elementary/Secon 6 th grad	cify only highest g ndary (0-12) C	rade completed) College (1-4 o na	or 5+)	life. Do	ind of work DNOT use I Domes	retired)		t of worki	ng	100	Priva		odony
Maryland 2 2 should be filed w th and Mental Hyg 27 is marked othe traumatic event,	_	17. Father's Name <i>(F</i> George R									e (First, Middi Cuce	e, Maide	n Surname)		
Mary d 2 should alth and N 27 is me er trauma		19a. Informant's Nar Mary Nic			er	4					Route Num Balt		,		,
Baltimore, sernit. Page 1 and Department of Hee mportant: If item mortant: If item my rainy or othe 200ce.	1			Removal from Sta	ite C6	lace of Dispo emetery, cren	natory or oth	her place			Date 28/20		Location - C		·
Balti permit. Departi Importe any inju		21. Si hatur of Fun	eral Service Licer	B. Ke	k	M ²	Name and	Addres	of Facility	št	Balt				-12)
Physician		23a. Par 1. Enter the shock, or heart Immediate Cause (F	inal	0 1	A	~	TALL	of dying	j, such as	cardiac o	r respiratory	arrest,			Approximate Interval Between Onset and Death
Medical Examiner		disease or condition resulting in death)		a. Have to (or a	as a consequ	ence of):	mu					-	,	1	6 years
kecuted and al-transit		Sequentially list con if any, leading to imr Cause (Disease or in	mediate lying njury	b. Due to (or a	as a consequ	ence of):					0 1	EXAM	INER		D YCGIS
760 rate be executed physician and it the burial-transit edical Examil	100	that initiated events resulting in death) L	ast	Due to (or a	as a consequ	ence of):				ION APPR	WED BY MED				
5876 ertificate ding phy se as th		IF FEMALE:		23c. If yes, outcon	ne of pregnar	acv		•	ERTIFIC						
f Vital Records, P.O. Box 68760 Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and ral director, page 2 should be detached for use as the burial-transition Be Completed by Physician/Medical Exam	in all citations	23b. Was decedent p in the past 12 m 1 ☐ Yes 2 ☐ 9 ☐ Unknown	nonths?	1 Live Birtl 4 Pregnan 9 Unknow	h 2 ☐ Fetal t at time of d	Ideath 3	Ectopic pr Other (spe		/			-	23d. Date Mont		ery Day Year
ords, P.O. Box requires that the death been signed by the atter should be detached for letted by Physicia	2	Part II. Other signific hyperten		_									_		ne cause of death?
Records, The law requires cate has been signage 2 should it	non-bics	leg frac	tures								pei	is an copsy formed?	pri de:	or to co ath?	psy findings available mpletion of cause of 2 No
Saptilization in sectificate has the director, page 2 s	3	25. Was case referred examiner?	d to medical	Hospital: 1 □ Inpa	atient 2 🗌	ER/Outpatien	t 3 🗆 DO	Othe	r.	_	only one)				429
		27. Manner of Death 1 Natural 2 X Accident	5 Pending Investigation			28b. Time of injury Unkno	- 1	c. Injury work?	at ? Yes 2 X	, I	28d. Describe Subjec Subjec	t fe	11 and	1	hed
Division tal or Attendin rs after death. al Director: Aft led in by the ful		3 ☐ Suicide 4 ☐ Homicide	6 L Could not l	28e. Place of I	etc. (Specify)		eet, factory,	office			28f. Location City or To Catons	(Street a	te) 711	or Rural \cad	Route Number, emy Road
To the Hospital Within 24 hours. To the Funeral I completely filled		(Check 2 only one) 3	 Medical Exan Certifying Nu 	ysician: To the best niner: On the basis o rse Practitioner: To	f examination	and/or invest	igation, in m death occur	y opinion red at th	n, death oc ne time, dat	curred at	the time, date	and place the cau	ce, and due to se(s) and mar	o the car nner as s	use(s) and manner stated. stated.
To with		29b. Signature and ti		rend C	ent		2	License	65E	3		03	ate signed (I	പ്പ	
2	(Friend	completed cause of	death (Item	23a) (Type, P	rint)	14 1	Wind	xv/	nille	an	2124	4	
State Registrar		31. Date filed (Month	2 6 2012	32. Regis	strar's Signati	park									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death March 20 Day 2012 Year Physician/ 12:24 A_{M} Debbie Rose Hamilton Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Prince George's Clinton Southern Maryland Hospital 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min (Month, Day, Year, 577-54-3505 73 1 □ M 2 🛚 F **Director** 1938 South Carolina or 28a-f show notified at 10d. Inside City Limits 10a. State 10c. City, Town or Location death with the Maryland Director 1 Yes 2 No Wagener SC Aiken 10e, Street and Number 10f. Zip Code ō 10g. Citizen of What Country? ıral", or items 23a or Examiner must be r Funeral 29164 U.S.A. 2524 New Holland Road 12. Was Decedent Ever in U.S. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian Armed Forces? Yes, specify Cuban, Mexican, Puerto Rican, etc. 1 Never Married 2X Married þ within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify. If Yes, Give Year or Dates Specify: Black "natural" 3 Widowed 4 Divorced Completed Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) of Health and Mental Hygiene. Item 27 is marked other than other traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) Federal Employee Government 12 Be Department of Health and Mental His Important: If item 27 is marked oth any injury or other traumair. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Rosie Lee Frazier Walter Guyton, Jr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2524 New Holland Rd., Wagener, SC 29164 Donna R. Hamiltom-Scott (Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place 1 X Byrial 2 A Cremation 3 Removal from State Baughmanville Baptist 3/25/2012 Wagener, SC 4 ☐ ponation \$ ☐ Other (Specify) Signature of Full 22. Name and Address of Facility Metropolitan Funeral Service Vine St., Alexandria, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betwe Inset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (a) resulting in death) Last physician Physician/Medical Box 68760 the as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year ed by the a g Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an page 2 certificate has performed 2 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 2 L No 1 Yes မ 1 Inpatient 2 L ER/Outpatient 3 DOA After this funeral 27. Manne of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 1 Natural 5 Pending 1 🔲 Yes 2 🗌 No within 24 hours after death

To the Funeral Director: A
completely filled in by the f ☐ Accident ☐ Suicide Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Exampler: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Sertifying Narse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated title of certific

DHMH 17 Rev 06-2011

State Registrar MAR 2 6

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ HERMAN F. HENSS, JR. Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** N/A GOOD SAMARITAN HOSPITAL BALTIMORE CITY 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours (Month, Day, Year) **Director** 212-30-3621 1**X**□ M 2 □ F 1/5/1933 MARYLAND 79 Usual Residence of Deceder 28a-f shov 10b. County 10a. State 10c. City. Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 Yes 2 XNo BALTIMORE PARKVILLE MD 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funera 3010 ORLANDO AVENUE <u> 21234</u> 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian med Forces Black, White, etc. o þ 1 Never Married 2 X Married 2 No If Yes, Give Year or Dates KOREAN 1 ☐ Yes 2 X No Specify: item z/ is marked other than "natural", other traumatic event, the Medical Exal Specify: WHITE Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working Department of Health and Mental Hygiene Important; if item 27 is marked other than any injury or other traumatic event, the Me life. DO NOT use retired) Elementary/Secondary (0-12) 6TH GRADE College (1-4 or 5+) **UPHOLSTERER** FURNITURE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ LYDIA RENSHAW HERMAN F. HENSS. SR. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BALTIMORE, MD 21234 3010 ORLANDO AVENUE MARJORIE HENSS/WIFE Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1 🗆 Burial 2 🔀 Cremation 3 🗆 Removal from State METRO CREMATORY, INC. 3/26/2012 CATONSVILLE, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. MO0217 8521 LOCH RAVEN BLVD. TOWSON, MD 21286 Part 1. Enter the disease, or complication, that cause the death. Do not enter the mode of dying shock, or heart failure. List only one cause on each time. Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical **Examiner** Years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of Examir Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last physician as the burial-Physician/Medical Box 68760 IF FEMALE: use 23b. Was decedent pregnant 23d. Date of delivery in the past 12 month ę Year Month Day 1 Yes 2 9 Unknown 9 Unknown P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has page death? 1 Tyes Yes Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 2 🖪 No Hospital Other: 1 Tes 1 Inpatient 2 FR/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) မ 24 hours after death.

Funeral Director: After this 27. Man of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: 28c. Injury at iniury 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check within 2 73 🗌 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature 29d. Date signed (Month, Day, Year) 38543 mpleted cause of death (Item 23a) (Type, Print) Name State

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Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Carolyn Marie Johnson 2012 March 21 1:30p Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carrol1 Golden Living Nursing Center Westminster 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthdav) 8. Date of Birth (Month, Day, Year, Birthplace (State or Foreign Country) **Funeral** Hours 216-28-7990 Director 1 🗆 M 2 💢 F 82 March 8 1930 MD Usual Residence of Deced 28a-f shov 10b. County 10a. State 10c. City. Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director Examiner must be notified MD Carrol1 Eldersburg 1 Yes 2 X No 5 10e Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral items 23a 21784 2023 Rudy Serra Drive USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 9 þ 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: Specify: white "natural" Completed 3 X Widowed 4 Divorced Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Elementary/Secondary (0-12) College (1-4 or 5+) the bookkeeper and accountant accounting traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Emily R. Hendricks Robert Huller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert F. Johnson (son) 327 Goldenrod Ct., Westminster, MD 21157 Department of Healt Important: If item 2 any injury or other t once. 20b. Place of Disposition (Name of cemetery, crematory or other p 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Garrison Forest Vet. 3-27-12 Owings Mills, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Haight Funeral Home & Chapel Signature of Funeral Service Licensee Dage Haight Sterbert P.O. Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner VeR 15e as Sequentially list conditions Examine if any, leading to immediate Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events physician ar s the burial-t resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No ģ Pregnant at time of death signed by the a Id be detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsy this certificate has page 2 1 Yes 2 No Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital Other: 1 Yes 2 No ျ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury work?
1 Yes 2 No 1 X Natural 5 Pending after death, Director: Aff d in by the fu 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 24 hours Medical 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier H0061206 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 688-c Poole Rd Westminsterm 2115 6 State MAR 2 6 2012 Registrar

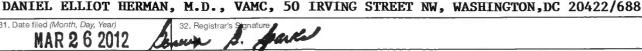
DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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	d		13 DRIFTWOO				BERLIN			WOR	CEST	
	Funeral Director		5. Social Security Number 579-56-6151	6. Sex 7. A	ge (In yrs. Ia	as <i>t birthday)</i> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt AUG• 14	Year 1946 C		lace (State or Foreign
	and show 1 at	o.	Usual Residence of Decedent 10a. State 10b. Cou	nty	10c, City	y, Town or L	ocation				11	0d. Inside City Limits
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036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Inpopartment of Health and Mental Hygiene. Inpopartment of Health and Mental Hygiene. It is marked outher than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ed by	1 ☐ Never Married 2 🛣 I 3 ☐ Widowed 4 ☐ Divor	Married 1 Yes 2	No		1 ☐ Yes 2 🛣 No		riiodii, oto.j	Specify:	White, e	ite. ite
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nore	age 1 a ent of H nt; If ite y or ot		20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremati 4 ☐ Donation 5 ☐ Othe	on 3 Removal from State	9 0	emetery, cre	oosition (Name of ematory or other place	1 1	Date / 2012	20c. Location - C	-	
رح Baltimore.	permit. P Departm Importar any injur	. 8	21. Signature of Fureral Service		_ Ca		Cremation 22. Name and Addres	s of Facility				MD 21074
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89	eath certifice attending p	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If <u>ye</u> s, outcome	of pregnar	ncy				23d. Date	of delive	ny.
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Division of Vital Records,	l or Att after de Directo			ld not be ermined 28e. Place of Inj building, et			reet, factory, office		28f. Location (Si City or Town	treet and Number on, State)	r Rural F	Route Number,
	To the Hospital or Attending Physician: The law requires that the death certification 24 hours after death. At the Funeral Director: After this certificate has been signed by the attending completed filled in by the funeral director, page 2 should be detached for use as	Medical	(Check 2 Medica	ing Physician: To the best of Il Examiner: On the basis of e	examination	and/or inves	stigation. In my opinio	 death occurred a 	t the time date an	nd place, and due to	the caus	se(s) and manner stated
	To the within 2 to the comple	ğ	29b. Signature and title of certily	ing Nurse Practioner To the fier	best of my	knowlidge.	29c. License	time, date and plan	te, and dee to the	29d. Date signed (A	er de etat	ted.
	(q_j)		▶ Angela 4					066164		1/24/1	2	
			30. Name and address of person	on who completed cause of c 10 10445 OU OU	teath (Item	23a) (Type,	Print) [#1, Balin	, MO Z18	1			
	Stat Registra	e	MAR 2 MAR 2	Registr	ar's Signa	ba	Med					

State Registrar 31. Date filed (Month, Day, Year, MAR 2 6 2012

29b. Signature and title of centifier



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

MD# 0101233709

29d. Date signed (Month, Day, Year)

MARCH 23, 2012

		Ple	ease Type or P						-		_	ble.	
		For State	State of N	Marylan		artment of		and M	lental Hy	giene	9		00000
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Physicia			,	kson					Month March	D	ay 20	Year 112	3. Time of Death 11:30 P ^M
Medic Examin		4a. Facility Name (if not institution				4b. City, Town,	or Location of	f Death	Pier CII		c. County o		111.30 1
		Golden Livin							inster		Ca	irro.	
* Funeral Director		5. Social Security Number	6. Sex 1 🔀 M 2 ☐ F		ast birthday) Yrs.	If Under 1 Year Months Days		24 Hrs. Min.	8. Date of Bir (Month, Da	y, Year)		Count	
		234-40-6636 Usual Residence of Decedent		86	0				Jan. 2	7, 1	1926	V11	rginia
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should be filed within 72 h and Mental Hygiene. 7 is marked other than "traumatic event, the Mec		Walter K. J 19a. Informant's Name/Relation			19b. Maili	ng Address (Stree			White Route Numbe	er, City c	or Town, Sta	te, Zip C	Code)
1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		Minnie L. Jack	son/wife		2470	Collisc	n Dr.	V	Vestmin	ste	r, MD	211	57
e 1 an t of He If item or oth		20a. Method of Disposition 1 → Burial 2 □ Crematic			Place of Dispo cemetery, crei	osition (Name of matory or other pla	ace)	C	Date	20c. l	Location - 0	ity or To	wn, State
permit. Page 1 Department of Important: If it any injury or o		4 Donation 5 Other	r (Specify)			ve Cemet			/2012		Air	_)
permit. Departr Importa any inju		21. Signature of Fineral Servic	i Con Xa	Ste	/ /	2. Name and Addr 1802 Lik					eraı ı town,		21762
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Medical Examiner		resulting in death)	Due to (or a	is a conseq	,								
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certific nding use as	N/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcor			75					23d. Date	of delive	ery
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To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the bu													
e Hosp 24 ho e Fune leted f	Medical	29a. Certifier 1 Leertify (Check 2 Medica	ring Physician: To the best al Examiner: On the basis of ring Nurse Practioner: To t	of my know of examination he best of m	rieage, aeath on and/or inves ov knowledae.	occured at the tin stigation, in my opi death occurred at	ne, date and p nion, death oc the time, date	piace, an ccurred at and plac	d due to the ca the time, date e. and due to ti	and plac ne cause	e, and due es and mar	to the cau	use(s) and manner stated ated.
To the within To the comp	2	29b. Signature and title of cert	PC O MI	le 1	M N	29c. Licen	se number	17	10	29d. D	ate signed	(Month, l	Day, Year)
		1	1000	, (-11)	17-1	1052	12	19	0	5-2	0-	2012
かく		30. Name and address of person	on who completed cause of R. Kane	f death (Iter	n 23a) (Type, 349	male	ilm d	Lu	E, W	est	min	tu	MD 3112)
Sta Registr		(Check only one) 3 Certify 29b. Signature and title oncert 30. Name and address of personal and title oncert 31. Date filed (Month, Day, Year	6 2012 32 Aegi	strar's Signa	atura d	ares							

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 1:10 P March 22, Patricia Frances Jagielski 2012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Baltimore 1305 Woodshole Road Towson If Under 1 Year Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Min Director 218-26-9022 82 1 M 2 X F 1/19/1930 Mary land Usual Residence of De 28a-f show 10a. State 10b. County 10c. City, Town or Location at 10d. Inside City Limits Director ms 23a or 28a-f s must be notified 1 🗆 Yes 2 ื No Mary land **Baltimore** Towson 10f. Zip Code 10g. Citizen of What Country? Funeral 1305 Woodshole Road 21286 U.S.A. items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Examiner Black, White, etc. ori ģ 1 Never Married 2 X Married 1 ☐ Yes 2 🛣 No If Yes, Give within 72 hours after Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify: 27 is marked other than "natural", traumatic event, the Medical Exar Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Engineering Firm 12 Secretary and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Charles J. Mouery Ida T. Cosik 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health item 27 Melvin John Jagielski / Husband 1305 Woodshole Road Towson, Maryland 21286 other 1 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of harmonic line limportant: If ite any injury or other Page 1 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 3/26/2012 Baltimore, Maryland 4 Donation 5 Other (Specify) Holv Rosary Cemetery al Service Licensee MC 1553 Miner 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence oil. Examil that initiated events resulting in death) Last Due to (or as a consequence of): physician a s the burial-Physician/Medical requires that the death certificate be Box 68760 as t IF FEMALE: JSe 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? ģ Month Pregnant at time of death Day Year 9 Unknown the Unknown P.O. signed by t Id be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes → No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy perform has pade Hospital or Attending Physician: The this certificate 2 No Yes 1 Yes 25. Was case referred to medica Be 26. Place of Death (Check only one) Hospita Other: 1 🗌 Yes ည t Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? Certificate: (Month, Day, Year) Natural 5 Pending injury n 24 hours after death.

le Funeral Director: Aft
bletely filled in by the ful M 1 Yes 2 No Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F only one 29b. Signature a icense number

Registrar

DHMH 17 Rev 06-2011

State

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. 20 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Month James Lucas Willie 03 201 6:45p. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Baltimore **Examiner** 4c. County of Death Joseph Richey Hospice If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours (Month, Day, Year) **Director** 49-34-9994 1 🛛 M 2 🗆 F 13 28 SC 04 83 Usual Residence of Deceder or 28a-f show notified at 10a. State 10b. County with the Maryland 10c. City. Town or Location 10d. Inside City Limits Director 1 Tes 2 No Randallstown MD Baltimore 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? rms 23a or Funeral 21133 U.S.A. 3408 Carroll Ave items ; within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, "natural", or iter edical Examiner Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: If Yes, Give Year or Dates Specify: 3 😾 Widowed 4 🗆 Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working than life. DO NOT use retired) 12th Grade College (1-4 or 5+) the Post Office Supervisor and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Irene Holmes permit. Page 1 and 2 should be Department of Health and Meni Important: If item 27 is marke any injury or other traumatic once. Newton Lucas traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Md 21133 4203 Paran Road, Randallstown, Mark Lee-Step-Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Burial 2 Cremation 3 Removal from State Donation 5 Other (Specify) cemetery, crematory or other place) Owings Mills, Md Garrison Forest 3/27/2012 21. Signature of Funeral Service Licen-22 Name and Address of Facility March F/H West 4300 Wabash Ave, a Baltimore, 21215 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) Cause (Disease or injury for use as the burial-tran that initiated events resulting in death) Last and Due to (or as a consequence of): Physician/Medical The law requires that the death certificate be Records, P.O. Box 687 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year Pregnant at time of death ate has been signed by the spage 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? After this certificate 2 No 1 Yes of Vital or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \(\) Nursing Home 5 \(\) Residence 6(\) Other (Specify) P. Hospital: 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 \square Pending work?
1 Yes 2 No Division Accident Investigation completely filled in by the within 24 hours after death To the Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined City or Town, State) Hospital Medical 29a. Certifier 📇 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only on 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 32580 2012

Registrar

DHMH 17 Rev 06-2011

State

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88 North Eutow Street, Baltimore, MD 21201

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2 6 2012

31. Date filed (Month, Day, Year)

INET

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Maticio, Ur. 1420PM James Mar Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death Examiner 4c. County of Death UMMC - Shock Trauma Center Baltimore Social Security Number 6. Sex 7. Age (In yrs. last birthday) Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months 214-15-7185 35 **Director** 1 **X** M 2 □ F Aug 2, 1976 MD or 28a-f show notified at 10c. City, Town or Location 10a. State 10d. Inside City Limits Director MD Carrol1 Union Bridge 1 Yes 2X No 10f. Zip Code 10e. Street and Number ò 10g. Citizen of What Country? ed other than "natural", or items 23a or event, the Medical Examiner must be i Funeral 4480 Priestland Road 21791 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status 14. Race - American Indian, Black, White, etc 1 Never Married 2 XMarried ģ 1 ☐ Yes 2 X No If Yes, Give X Year or Dates. Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify. Specify: white 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within 72 th and Mental Hygiene.
7 is marked other than "r. Elementary/Secondary (0-12) College (1-4 or 5+) excavation & paving paver/excavator 12 Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) ည James Lee Maticic Sr. Ruth Ann Beechan other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health an Important: If item 27 is any injury or other trau Rebecca Maticic (spouse) 4480 Priestland Rd., Union Bridge, MD 21791 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2X Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) All County Cremation 3-27-12 Sykesville, MD 21. Signature of Funeral Service Licer 22. Name and Address of Facility Haight Funeral Home & Chapel whet I Duena MO1314 Box 195 Sykesville, MD 21784 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Ph_sician/ traumatic brain in IUI disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** days Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Exami Due to (or as a consequence of) attending physician I for use as the buris Physician/Medical The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy5 Other (specify) in the past 12 months?
1 \(\subseteq \text{ Yes} \quad 2 \subseteq \text{ No} \) Month Day Year Pregnant at time of death the a signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an cate has I performed certificate 2 No 1 Yes Yes 2 X No Hospital or Attending Physician: 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Other: 4 \(\sum \) Nursing Home 5 \(\sum \) Residence 6 \(\sum \) Other (Specify) 2 🗌 No ျှ 1 Natient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completely filled in by the funer 5 Pending Mar 18,2012 1 Natural 2 Accident ATV accident 0100 AM 1 Yes 2 X No Investigation 3 Suicide 4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) MCKinstrys Mill Road Union Bridge ND 2179 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined home Medical 29a. Certifier 1 💹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) Mar 23 2012

DHMH 17 Rev 06-2011

State

Registrar

S. Greene St

Bultimora, MD 21201

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Bridges

Year) -

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31. Date filed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department and Mental Hygiene 2 0 1 2 0 0

				Item 23a per	är.,	g925 Cer	tificat	e of L	Death			Reg. No	2012	09201
	Physicia	an/	Decedent's Name (First, Middle,	Leo Alto	n Muff	lov					2. Date of De Month MCUCK		ay Year Z	3. Time of Death 5258 P M
	Medi Exami		4a. Facility Name (if not institution,		II IVIUII	icy	4h City	Town or	Location o		na cr		c. County of Death	
	Exami	iei	Doctor's Communit				45. Oity,	104411, 01	Lanh			1		George's
	Funeral			6. Sex 7. Age	e (In yrs. las	t birthday)	If Unde		If Under 2	24 Hrs. 8	B. Date of Birt	th	9, Birth	place (State or Foreign
- 1	Director		159-36-3726	1 X M 2 □ F	66	Yrs.	Months	Days	Hours	Min.	06/0	8/194	.5 P	ennsylvania
	and show d at	٦	Usual Residence of Decedent 10a, State 10b. County	}	10c City	Town or Lo	cation						T	10d. Inside City Limits
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	he Ma or 28 noti	<u>F</u>	10e. Street and Number	ce deorge's			10f. Zip	Code	DOW	/10		10a. C	itizen of What Cou	
	with t	Funeral Director	9000 Wipkey Court						2072	20		3	US	
	leath items er mi	E	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S.	13. V	Vas Dece	dent of Hi		-	fy Yes or No- can, etc.)		14. Race - Ameri	can Indian,
9	ufter o	ğ	1 Never Married 2 Marri	ed 1 X Yes 2 If Yes, Give	No Arm	у			Specify:	, ruerto ni	can, etc.)	l	Black, White,	etc.
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3	within siene.	S	Elementary/Secondary (0-12) 12	College (1-4 or 5	+)				urier				Healtl	ncare
175	filed all Hy	Be c	17. Father's Name (First, Middle, La	ast)					18. Mothe	er's Name (l	First, Middle,	Maiden	Surname)	
20 5	VICE Ild be Ment Ment arke	욘		William Muffle	ey						S	tella	Webb	
7	shou and ris m		19a. Informant's Name/Relationsh	. ,	- 0		_					r, City o	r Town, State, Zip	Code)
A.	and 2 Health em 2; ther t		Barry Louis Muffley 20a. Method of Disposition	/ Son	Took Die	900 ice of Dispo			urt, Bo		D 20720	00. 1		
Muffley, he	perillingtey, Marylatiu Z 12.13-0030 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho- may injury or other traumatic event, the Medical Examiner must be notified at once.	Ĺ	1 🗆 Burial 2 🗶 Cremation		cer	netery, cren	natory`or o	ther plac		Dat		20c. L	ocation - City or T	
Z i	nit. Pa artme ortan injury		4 Donation 5 Other (S) 21. Signature of Funeral Service Li			Chesapea			y s of Facility	3/20/	2012		Beltsvill	e, MD
á	Dep Dep Out		Dorota Marshall	unto Willa	Shall)				•	ces. PO l	Box 1	413 Baltime	ore, MD 21203
			23a. Part 1. Enter the disease, or shock, or heart failure. List or	complications that caused	the death.	Do not ente								Approximate Interval Between
17.00	Physician/		Immediate Cause (Final disease or condition	Head	LT	Elv	~_							Onset and Death
4	Medical Examiner		resulting in death)	Due to (or as a	conseque	nce of):	/ Co	onjes	stive	Hear	t Fail	ure		
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d'	ed	Ë	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	con s quei	nce ot):								
2	xecut n and al-trar	Exa	that initiated events resulting in death) Last	c. Due to (or as a	conseque	nce of):								
8	Attending Physician: The law requires that the death certificate be executed at death. **redeath.** **setor: After this certificate has been signed by the attending physician and but the funeral director, page 2 should be detached for use as the burial-transit	Medical Examiner		d										
,9 02/60	ifficate	Med	IF FEMALE:											
C	h cert tendir or use		23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of	of pregnance 2 Fetal of	cy death 3 🗆	Ectopic	oregnanc	у				23d. Date of deliv	
S S	e deat the at hed fo	ysic	1 Yes 2 No 9 Unknown	4 ☐ Pregnant at 9 ☐ Unknown	time of dea	ath 5∟	Other (s	pecify)					Month	Day Year
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month no am Martha Martin Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 2924 Arunah Ave. Baltimore N/A8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** ial Security Numbe 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 213-18-3476 Hours Min. **Director** 1 M 2 X F 102 01/05/1910 Maryland Usual Residence of Decedent 28a-f show 10c. City, Town or Location must be notified at Director 1 X Yes 2 No MD N/A Baltimore 5 10e. Street and Number 10g. Citizen of What Country? Funeral 23a 2924 Arunah Ave. 21216 U.S.A. permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married ☐ Yes Yes, Give Baltimore, Maryland 21215-0036 2 **X** No 1 ☐ Yes 2 😾 No Specify: Specify: Black 3 Wildowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Baltimore City (Specify only highest grade completed) 12th Grade College (1-4 or 5+) Teacher's Aide Public Schools Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 William Hackett Martha Smith 19a. Informant's Name/Relationship (Type, Print) Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9641 Ashlin Cir., Owings Mills, MD 21117 Elvira McGlaughlin 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🔀 Burial 2 □ Cremation 3 □ Removal from State cemetery, crematory or other place) MD Nat'L Cemetery 03/20/12 Donation 5 Other (Specify) Laurel, MD re of Funeral Sergice Licensee 3 Osephod H. Brown Jr. Funeral Home PA 2140 N. Fulton Ave., Baltimore, MD21 Baltimore, MD21217 art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onser and Death shock, or heart failure. List only one cause or such line. 4 Immediate Cause (Final disease or condition Physician/ Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any tree of the cause. Enter Underlying Examil Cause (Disease or injury that initiated events resulting in death) Last burial-tran and Due to (or as a consequence of): nding physician a use as the burial-Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ atten for u in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day signed by the at Id be detached for Pregnant at time of death Unknown g Unknown Division of Vital Records, P.O. nificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 2 DNo 3 □ Probably 4 □ Unknown Completed page 2 should been 24b Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes Other: 21 ျာ 1 Inpatient 2 ER/Outpatient 3 IDOA METHA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred the Hospital or Attending 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number. City or Town, State) within 24 hours a

To the Funeral C Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed Month, Day, 31. Date filed (State

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State		State of M	aryıar			te of E			_	0010	00070
			Registrar 1. Decedent's Nam	e (First, Middle, La	ast)		Cer	unca	le oi L	Jean I	2. Date of De	Reg. N	10.	3. Time of Death
П	Physicia			Janene	Kay Oette	21					Month March)ay Year 2012	
100	Medic Examir		4a. Facîlity Name (ii		re street and number)			4b. Cit	y, Town, or	Location of Deat			c. County of Dea	
-			8684 1	Felsview	Drive				Laure	21			Howard	
	Funeral Director		5. Social Security N 380-70-02	238	Sex 7. Ag 1 □ M 2 □ X F	e (In <i>yrs. I</i>	ast birthday) Yrs.	If Und Month	er 1 Year B Days	If Under 24 Hrs Hours Min.		th i <i>y, Year)</i> 1	9. Bir 960 Mic	thplace (State or Foreign untry) higan
	nd at	Ļ	Usual Residence of 10a. State	Decedent 10b. County		10c Cit	y, Town or Loc	ation						10d. Inside City Limits
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	he Mi or 28 s noti	盲	10e. Street and Nur				Daulei	10f. Z	ip Code			10a. C	Citizen of What Co	
	with s 23a ust b	eral	8684 F	elsview	Drive				207	23		0	USA	•
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Maryland 21215-0036	rs after or ural", or Examin	Completed by Funeral Director	1 ☐ Never Marr 3 ☐ Widowed	ried XX Married 4 Divorced	1 Yes 21X If Yes, Give Year or Dates.				₩X No		o Alcan, etc.)		Black, Whit	_{e, etc.} hite
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2	ed wil Hygie other	Be C	12t 17. Father's Name (5+		<u>I</u>	<u>iter</u>	<u>natio</u> T	nal Stud		•	vson Uni	versity
au	be filk ental ked c	인	,	Howard Oe						18. Mother's Nar	ne (First, Middle, Betty Me		•	
ary	nd Missing Mark		19a. Informant's Na				19b. Mailin	a Addre	ss (Street a	and Number or Ru			or Town, State, Zij	n Code)
	d 2 shealth a		Michael	Anthony	Lorei/Husb	and	1			w Drive,				•
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disp		Removal from State	0	Place of Disposemetery, crem	atory or	other place	· .	Date		Location - City or	
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8760			IF FEMALE:											
× 68	ath certifica attending p	ian/	23b. Was decedent in the past 12		23c. If yes, outcome 1 Live Birth	2 Feta	al death 3	Ectopia	pregnanc	у			23d. Date of de	•
Box	the at	Physician/M	1 ☐ Yes 2 🔀 9 ☐ Unknown	☐ No	4 ☐ Pregnant a 9 ☐ Unknown	t time of o	death 5	Other (specify)				Month	Day Year
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orc	w require s been s s should	plet									24a. Was		24b. Were au	topsy findings available
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₹	Physic this ce al dire	은	1 ☐ Yes 2 🛭				ER/Outpatien	3 🗆	Othe	r: 4 🗌 Nursing F	ome 5X Resid	dence	6 Other (Spec	ify)
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		1- For State Certifica Registrar	te of Ç eath	Re	eg. No.	
Physici Medical Exami	an/	Decedent's Name (First, Middle, Last)		Date of Deat Month	Day Year	3. Time of Death 1515 hrs
wedical Exami	ner	Alvin Lee Oliver 4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Dea	March 19,	4c. County of Death	
		2580 West Mulberry Street	Baltimore	uı	N/A	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birtho		-	th (MM/DD/YYYY) 9. Bird	
Director		212-46-4498 _{1km} ₂ _F 65	Yrs. Months Days Hours M	n. 02/17	/1947 Foreig	n untry) MD
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Aaryland 28a-f sho	향	MD N/A B	altimore 10f. Zip Code		og Citizen of What Cour	
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215-0036 be filed within 72 ntal Hygiene. rked other than "	ng l	1	usekeeping		Charles T	own
		17. Father's Name (First, Middle, Last)	18. Mother's Nan	ne (First, Middle, M	flaiden Surname)	
121 d be fi ental	Be	General Lee Oliver Sr.	Mozel	la Hodg	e	
MD 21215-0036 12 should be filed within 7 th and Mental Hygiene. 127 is marked other than umatic event, the Medical	٩		Mailing Address (Street and Number of 13 Aberdeen Ave			
'e, M 1 and 2 Health 'item 2	H	20a. Method of Disposition 20b. Place of	Disposition (Name of cemetery,	Date	20c. Location - City or	
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Baltimore, permit. Pages 1 and Department of Heal Important: If item injury or other tra		In Ignatus of Funeral Service Lice se	23 Name and Address (5 Swift J	r. Fune	ral Home	PA
			2140 N. FUlton	Ave.,	Baltimore	, MD21217
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876 bificate ng phy as the b		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1	Fetal death 3 Ectopic pregi	nancy	23d. Date of delivery Month) Day Year
Box 68760, death certificate but the attending physic of for use as the but	icia	past 12 months? 4 Pregnant at time of 5	Other (Specify)		1	
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<u></u>	atio	1 V Natural 5 Pending 2 Accident Investigation	1 Yes 2 No			
Division pital or Attendion ours after death. teral Director: A	Certification:	Suicide Could not be determined (Specific)	n, street, factory, office building, etc.	28f. Location (S or Town, St	Street and Number or Ru tate)	ral Route Number, City
E 6 5		4 Homicide 29a. Certifier Certifier Physician To the heat of my knowledge death	accounted at the time, date and place, or	ad due to the source	o(a) and manner as state	ad.
Divis To the Hospital or A within 24 hours after or To the Funeral Direc	Medical	one) 2 Medical Examiner; On the basis of examination and/or inv				
To cor	Ř	and manner stated. 29b. Signature and title of certifier	29c. License number		29d. Date signed (Mor	nth, Day, Year)
		Chrest 2	O.C.M.E.		March 20, 2012	
		30. Name and address of person who completed cause of death (Item 23a)	Dalkinson Office D. 10	ID 04000		
		Ana Rubio MD. Assistant Medical Examiner 900 W. 31. Date filed (Month, Day, Year) 33 Registrar's Signature	baitimore Street, Baltimore, N	1D 21223		
Regis	City		excel			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ RAMONA PRESA MARCH 22, 2012 2:45A Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death CALVERT CO. NURSING CENTER PRINCE FREDERICK CALVERT . Social Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** Birthplace (State or Foreign Country) Hours 170-34-8635 Director 1 □ M 2 🔀 F May 10, 1917 Kansas Usual Residence of Decedent show notified at 10a. State 10b. Count 10c. City, Town or Location Director 10d. Inside City Limits 28a-f Maryland Calvert Huntingtown 1 Yes 2X No 10e. Street and Number ö 10f. Zip Code must be r 10g. Citizen of What Country? Funeral 3721 Hollyberry Drive 20639 U.S.A. items 2 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Hygiene. other than "natural", or iter ent, the Medical Examiner. 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married þ 72 hours after Baltimore, Maryland 21215-0036 1 X Yes 2 □ No Specify: Spain 3 Nidowed 4 Divorced Completed White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) and Mental Hygien is marked other ti Cafeteria Worker 8 Food Service Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Genaro Alvarez Adela Rodriguez permit. Page 1 and 2 should be Department of Health and Men Important; If item 27 is marke any injury or other traumatic traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Victor Michael Presa (Son) 3721 Hollyberry Dr., Huntingtown, MD 20639 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Sacred Heart Cemetery 3/26/2012 4 Donation Other (Specify) Monongahela, PA 21. Signature of Fun 22. Name and Address of Facility
Metropolitan Funeral Service
5517 Vine St., Alexandria, VA 22310 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Atheroscienotic Onset and Death Ph si i n (ardiovasular disease disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to for as a consequence of, Examir The law requires that the death certificate be executed and Due to (or as a consequence of): resulting in death) Last physician a Physician/Medical Box 68760 attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? for 5 Other (specify) Month Pregnant at time of death Day Year the hed h Yes 2 No g Unknown Unknown P.O. been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Dementio Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Kunknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performe 1 Yes 2 No Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medica Be 26. Place of Death (Check only one) Hospital 2 No 1 Yes Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 P Natural 5 Pending injury work?
1 Yes 2 No within 24 hours after death To the Funeral Director: A Accident Investigation 3 Suicide 6 Could not be filled in by Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated | Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely

Division of Vital Records,

State Registrar

W DHMH 17 Rev 06-2011

(Check

29b. Signature and title of certifier

Church 31. Date filed (Month, Day, Year) 32. Registrar's Signature

Deale

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

GYAN

D. 50653

29d. Date signed (Month, Day, Year)

SURANA

3-22-2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 20 | 2 0 9 2 7 3 State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar	Certifica	te of Death		Reg	j. No.	
Physic Medical Exam		Decedent's Name (First, Middle,Last) Peirut Ponciano				2. Date of Death	Day Year	3. Time of Death 1850 hrs
		4a. Facility Name (if not institution, give street and numb Johns Hopkins Hospital	er)	4b. City, Town, o Baltimore	or Location of Death		4c. County o	
Funeral Director		1 ^X M 2 F	Age (In yrs. last birtho	day) If Under 1 Ye Months Day		8. Date of Birth		9. Birthplace (State or unk Foreign Country)
id how any	_	Usual Residence of Decedent 10a. State 10b. County MD	10c. City, Town or Balti					10d. Inside City Limits 1 Y Yes 2 No
th the Maryland 23a or 28a-f show notified at once.	Director	10e. Street and Number 13 S. Fulton Avenue		10f. Zip Code 21 223	3	10(g. Citizen of Wha	
r death with or items 23	Funeral	11. Marital Status UNK 1 Never Married 2 Married Armed Force 1 Yes	ent Ever in U.S. es?unk 2 No	13. Was Decedent of Hi If Yes, specify Cuba	n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	White,	
MD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiens and Parland and 23 or 28s-f she parl is marked other than "natural?" or items 23s or 28s-f she mastic event, the Medical Examiner must be notified at once	pleted by	3 Widowed 4 Divorced If Yes, Give Year or Dates. 15. Decedent's Education (Specify only highest grade or Elementary/Secondary (0-12) College (1-4 or Elementary/Secondary (0-12)	dı	1 Yes 2 No ecedent's Usual Occupa iring most of working life	ation (Give kind of w	ork don e ink ed)		white iness/Industry unk
215-0036 re filed within 7 tal Hygiene. ked other than int, the Medica	Be Comp	unk unk 17. Father's Name (First, Middle, Last) unk			18.Mother's Name	(First, Middle, Ma	iden Surname)	unk
MD 2121 and 2 should be fill alth and Mental F m 27 is marked sumatic event, 1	To	19a Informant's Name/Relationship (Type, Print) O • C • M • E •		Mailing Address (Stre	imore St	; Baltim	ore, MD	21223
Baltimore, IV permit. Pages and 2 Department of Health Important: If item 2 injury or other traus		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from 4 Donation 5 X Other Specify: in State	State cremator	Disposition (Name of ce y or other place)				City or Town, State
_ =====================================		Jenivar ///XVX	regtor	22. Name and Addres	altimore :	St; Balt	imore,	MD 21201
Physician V disal Examiner		23a. Part I. Enter the disease, or complications that cause failure. List only one cause on each line. Immediate ause (Final disease or condition resulting in death) a. Intracer Due to (or as a condition resulting in death)	ebral Hem		, such as cardiac or	respiratory arres	t, shock, or hear	Approximate Interval Between Onset and Death
	Je.	Sequentially list conditions, if any, leading to immediate b. Hyperten Due to (or as a corr	sion					
ecuted and - transit	Examiner	C. Due to (or as a cord.) Consease or injury that initiated events resulting in death) Last Due to (or as a cord.)	sequence of):					
760, cate be executed physician and the burial - transitions.	Medical	x UNPENDED AMENDED 23		r me,g926 4	4-10-12 sı	n		
ox 68 ath certificate at tending or use as t	Physician/M	23b. Was decedent pregnant in the past 12 months?	ome of pregnancy 2 at time of death 5	Fetal death 3 Other (Specify)	Ectopic pregnar	ncy	23d. Date of d Month	elivery Day Year
P.O. Les that the igned by the detached	á	Part II. Other significant conditions contributing to dea	ath but not resulting in	n the underlying cause	given in Part I.			ute to the cause of death? Probably 4 Unknown
of Vital Records, ng Physician: The law requir this certificate has been s meral director, page 2 should t	Completed			<u> </u>		24a. Was an autopsy perform 1 ✔ Yes 2	pri ed? de	ere autopsy findings available or to completion of cause of ath? Yes 2 No
certifi ector,	8	25. Was case referred to medical examiner? 1 Ves. 2 No. Hospital: 1 Vers. Inpat			of Death (Check of			
1 of Vi ling Physi After this funeral dii	ñ: To	27. Manner of Death 28a. Date of Ir		ne of Injury 28c. Inju		Home 5 Re 28d. Describe how		Other:
Division tal or Attendir rs after death. al Director: A	Certification:	2 Accident Investigation Suicide 6 Could not be 28e. Place of		1 1	Yes 2 No puilding, etc. 2	28f. Location (Stre		or Rural Route Number, City
Hospi 24 hou Funer	Medical Cer	4 Homicide determined (Specify) 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examiner:				due to the cause(s	s) and manner a	
To the within To the comple	Med	and manner stated	<u> </u>	29c. Licens	se number	2	9d. Date signed	(Month, Day, Year)
		30. Name/and address of person who completed cause of	, ,	O.C.			March 5, 201	12
St	ate		ar's Signature	00 W. Baltimore S	treet, Baltimore	e, MD 21223	-	
Regist	rar	31. Date filed (Month, Day, Year) NAR 2 6 2012	A. 100	ares				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#18perFH, G925, 3/27/2012, WS
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First Middle Last 2. Date of Death 3. Time of Death Physician/ Month 03 Year 10 2012 Medical 4a. Facility Name (if not institution **Examiner** ocation of Death 4c. County of Death AlliMORE **Funeral** 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) NCRTH CAROLINA 8. Date of Birth 1 🗆 M 2 🕽 Months Hours Min Director 1116/1916 Usual Residence of Decedent 10a. State 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location **Funeral Director** 10d. Inside City Limits ms 23a or 28a-f s must be notified BALTIMORE MD Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? FRANK FOR D AVENUE U.S.A. ral", or items? Examiner mus 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Completed by Black, White, etc. 1 Never Married 2 Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. "natural", 3. Widowed 4 ☐ Divorced Specify: BLACK Year or Dates It of Health and Mental Hygiene.

If item 27 is marked other than "nature or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) DomES: Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Riddick IDDICK 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21207 FANNIE HARDAWAY EWELLEN AVE. BALTIMORE M NIECE 20a. Method of Disposition 20b. Place of Disposition (Name of Department of H Important: If ite any injury or ot once, 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place 4 Donation 5 Other (Specify) 29 2012 BALTIMORE, MARY LAND E DERRICK C. JOINES FIH, P.A. Signature of Funeral Service Licensee 22. Name and Address of Fax BALTIMORE, M.Q. 21215 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrests shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last and The law requires that the death certificate be exec Due to (or as a consequence of): attending physician for use as the buria Physician/Medical P.O. Box 68760 IF FEMALE: IF FEMALE: 23b. Was decedent pregnan past 12 months? 23d. Date of delivery ate has been signed by the atte page 2 should be detached for Month Day Year 1 Yes 2 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate the completed filled in by the funeral director, page performe 2 🗌 No 1 🗌 Yes To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Hospital: Other: 잍 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death

1 Natural

Accident 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 5 Pending work?
1 ☐ Yes 2 ☐ No Investigation M Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated title of certifie ompleted gause of death (Item 23a) (Type, Print) Walthay Woods hd HO / Day, Year)

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

For State of M		artment of Healt		lygiene 201	2 09275
Registrar	Cer	tificate of Deatl		Heg. No.	2 03213
1. Decedent's Name (First, Middle, Last) Physician/ Marcarat Fligsbath P	4-1		2. Date of Month 03		3. Time of Death
Medical Margaret Elizabeth R	lichardson	Lu ou T		20 2012	
Fxaminer 4a. Facility Name (if not institution, give street and number) 7221 Lanham Lane		4b. City, Town, or Location		4c. County of D	
	e (In yrs. last birthday)		der 24 Hrs. 8. Date of I	Birth 9.	George's Birthplace (State or Foreign
Director 578-58-7294 1 □ M 2 🖫 F 67	7 Yrs.	Months Days Hour		Day, Year)	Country)
	10c. City, Town or Loc	action	06/17	7/1944	DC
10a. State 10b. County MD Prince George's 10e. Street and Number	1				10d. Inside City Limits 1 Types 2 No
MD Prince George's	Fort Was	10f. Zip Code		10g. Citizen of What	21
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19a. Informant's Name/Relationship (Type, Print)	19b. Mailir	g Address (Street and Nun	mber or Rural Route Num	ber, City or Town, State,	Zip Code)
Trena Parker/Daughter		South Monroe	e St. Arlir		
		natory or other place)	Date	20c. Location - City	
4 Donation 5 Other (Specify)		tion Cemet.		4	
1 LXBurial 2		Name and Address of Fact 217 9th St.			
23a. Fart 1. Enter the disease, or complications that caused	the death. Do not ente				Approximate
shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition Atheros		eart Disease			Interval Between Onset and Death 2006
	a consequence of):	care biscase			2000
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27. Manner of Death 1 X Natural 5 Pending (Month, Day	ry 28b. Time of	28c. Injury at work?		how injury occurred	33.177
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28a. Date of injunction of Death To be a great of the part of the	ury - At home, farm, stre c. (Specify)	et, factory, office		(Street and Number or i own, State)	Rural Route Number,
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(Check 2 Medical Examiner: On the basis of examiner: On the basis of examiner: To the only one) 3 Continuous Practitioner: To the					
29b. Signature and title of condier	7-	29c. License numbe	er	29d. Date signed (Mo	nth, Day, Year)
Julia Hale	140	DC 4502		03/22/2012	2
30. Name and address of person who completed cause of de William R. Frederick, MD		rint) St. NW #304	4 Wachington	DC 20010	
State 31. Date filed (Month, Day, Year) 32. Registra	ar's Signature	, DE. NW 1/304	+ washington	, DO 20010	
Registrar MAR 2 6 2012	1 pa	KI			

DHMH 17 Rev 06-2011

Registrar DHMH 17 Rev 06-2011 MICHAEL

lacelphia Ro. #314

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2012 Year Beulah Mae Seelhorst 24 9:15 March Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Chesapeake House Baltimore Middle River Social Security Number If Under 1 Year I If Under 24 Hrs. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** April 7, 1921 1 M 2 X F Months Hours 219 05 8530 90 Director Maryland Usual Residence of Decedent 28a-f show 10b. County at 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified Delaware Sussex Millsboro 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò Funeral with 23a 32816 Captains Way 19966 USA or items 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian Armed Forces Black, White, etc. þ 1 Never Married 2 Married 2 XNo ☐ Yes Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Specify: White "natural", 3 🕅 Widowed 4 🗆 Divorced Completed Year or Dates other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Il Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) Homemaker Own Home and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Emory Leonard Downey Mary Donnelly 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 Albert Brockmeyer (Son) 32816 Captains Way Millsboro, Delaware 19966 Page 1 and 2 item Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State permit. Page 1 Department of Important: If it ō 1 X Burial 2 Cremation 3 Removal from State Gardens Of Faith Cemetery 3/27/2012 Baltimore, Maryland injury (4 ☐ Donation 5 ☐ Other (Specify) Sign rule of Funeral Service License 22. Name and Address of Facility
Bruzdzinski Funeral Home P.A. any okn W. 1407 Old Eastern Avenue Essex Maryland 21221 23d. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Physician/ Pneumonia disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner General Debility Sequentially list conditions. Due to (or as a consequence on) Examine il any, leaving to immediate cause. Enter Underlying Cause (Disease or linjury Alzheimers Dementia death certificate be executed sician and burial-trans that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 the attending pl IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? 1 ☐ Yes 2 No Month Year Pregnant at time of death 9 Unknown 9 Unknown P.O. ed by t detach signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Hypertension Division of Vital Records, law requires 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown been signatures should be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas page 2 autopsy performe To the Hospital or Attending Physician: The certificate 1 Yes 2 X No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Nother (Specify) 2 X No ည 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After 1 1 🛚 Natural 5 Pending work' death. 1 Yes 2 No I Director: A Investigation 6 Could not be Accident Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined hours after within 24 hours af

To the Funeral Di

completed filled in Medical Scertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Dr. Ba Yin Oung 31. Date filed (Month, Day, State MAR 2 6 2012 Registrar

29a. Certifier

only one)

29b. Signature and title of certifier

8022 Belair Rd. Baltimore, Maryland 21236

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29d. Date signed (Month, Day, Year)

March 26, 2012

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29c. License number

D17728

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Mary Jean Stairs March 2012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Stella Maris Hospice Baltimore Timonium 8. Date of Birth (Month, Day, Year) 5. Social Security Number If Under 1 Year | If Under 24 Hrs. . Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months 220 22 1633 Davs Hours Director 84 1 🗆 M 2 🔀 F July 14, 1927 Maryland Usual Residence of Deced 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits be notified at Director Baltimore Middle River Maryland 9 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? permit. Page 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a any injury or other traumatic event, the Medical Examiner must be Funeral 3303 Gentian Lane USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force Black, White, etc þ 1 Never Married 2 Married 1 ☐ Yes : 2 X No Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: 3 X Widowed 4 □ Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Seamstress Clothing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Walter Aberts Ethel Forsythe 2012 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code Linda Hankins (Daughter) 3305 Foxglove Lane Baltimore, Maryland 21220 25, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 🛚 Burial 2 🗆 Cremation 3 🗆 Removal from State Parkwood Cemetery 3/30/2012 Baltimore, Maryland 4 Donation 5 Other (Specify) . Signature of Funeral Service License 22. Name and Address of Facility Bruzdzinski Funeral Home P.A. 1407 Old Eastern Avenue Essex, W Maryland 21221 At 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Phylician/ disease or condition resulting in death) CHRONIC OBSTRUCTIVE PULMONARY DISEASE Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine cause (Disease or injury that initiated events cum to for each por securions or resulting in death) Last Due to (or as a consequence of). burialphysician Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No for Month STAIRS Pregnant at time of death Day 9 Unknown 9 Unknown s been signed by ti should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has page 2 certificate 1 Yes 2 No Yes 2 No To the Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 X No 1 Yes ၉ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 X Other (Specify) HOSPICE After this funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending iniury work? 1 ☐ Yes 2 ☐ No M I Director: A Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) within 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 X Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title 29d. Date signed (Month, Day,

3. Time of Death

1 Yes 2 No

Year

Unknown

Ам

1:10

DHMH 17 Rev 06-2011

State

Registrar

2300 DULANEY VALLEY RD.

TIMONIUM, MD 21093

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CRNP

TRACIE L. MORGAN,

Date filed (Month, Day

MAR 26

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - State of Maryland / Department of Health and Mental Hygiene Registrar

State of Maryland / Department of Health and Mental Hygiene me, g97.5,03/21/2012dhb

Certificate of Death

Reg. No. Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year 2012 Month Physician/ рм Ruth I. Soltis 1828 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Timonium Lorien Mays Chapel If Under 1 Year If Under 24 Hrs Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Min. (Month Day Year) 9 1 D M 2 🔀 F Months Days Hours Country) 82 3 PA Director 168-22-9771 Usual Residence of Decedent Show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at Director 28a-f 1X Yes 2 □ No Borough of Philipsburg PA Centre 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Health and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or other traumatic event, the Medical Examiner must be 1 Completed by Funeral permit, Page 1 and 2 should be filed within 72 hours after death with 300 North 9th Street 16866 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11 Marital Status Armed Forces?
1 ☐ Yes 2X No Black, White, etc. 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify: White If Yes, Give Specify: 3 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) 1 2 College (1-4 or 5+) Domestic Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Franklin Shugarts Cora Shaw 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9th St., Philipsburg, PA 16866 Joseph E. Soltis other item 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 20a, Method of Disposition Department of h Important: If ite any injury or oth 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Philipsburg, PA Ss. Peter & Paul 2/1/12 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Harman Funeral Service 7221 Grayburn Dr., Glen Burnie, MD 21061 23a. Part HEnter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a cons of uence of) **Examiner** Sequentially list conditions, cause. Enter Underlying Cause (Disease or linjury CERTAL CHICATION FOR THE DICAL EXAMINER Examine Due to for as a consequence of attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical the Hospital or Attending Physician; The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year the a detached 9 Unknown g Unknown by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? within 24 hours after death.

To the Funeral Director: After this certificate has been signed b completed filled in by the funeral director, page 2 should be det Completed by Lumbar Abscess 1 Yes 2 No 3 Probably 4 Unknown from Laminectomy for Lumbar Stenos. 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner (Other: Nursing Home 5 - Residence 6 - Other (Specify) 2 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending work' 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆 only one) 29b. Signature and title of certifie 29d. Date signed (Month,

DHMH 17 Rev 7/2009

State Registrar 30 Name

31. Date filed

Registrar's Signature

N.Charles St

12-02192

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Steven M. Schultz	State Of 1- For State Registrar	f Maryland / Department Certificate		ygiene Reg. No. 20	12 0928
Physician/ Medical Examiner	Decedent's Name (First, Middle,Last)			2. Date of Death Month Day Year	3. Time of Death 1802 hrs
vieuicai Exammer	Stev 4a. Facility Name (if not institution, give s	ven Michael Schult treet and number)	Z 4b. City, Town, or Location of Death	March 16, 2012 4c. County of	
	Baltimore Washington Medic		Glen Burnie	Anne Aru	
Funeral Director	5. Social Security Number 6. Sex	7. Age (In yrs. last birthday	Months Days Hours Min		Foreign
Birestor	213-13-9479 1 X M	1 2□F 25	Yrs.	July 10, 1986	Country)Maryland
/ any	10a. State 10b. County	10c. City, Town or L	ocation		10d. Inside City Limits
yland I-f show	Maryland Anne Arun	ndel	Severn	140- 08	1 Yes 2 X No
the Marylan a or 28a-f sl tiffed at one Director	10e. Street and Number	•	10f. Zip Code	10g. Citizen of Wha	
r death with the Maryland or items 23a or 23a-f sho must be notified at once. Funeral Director	8270 Portsmouth Dr		21144 Was Decedent of Hispanic Origin? (Sp	pecify Yes or No- 14. Race -	American Indian, Black,
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2 hour "natu	Elementary/Secondary (0-12)		ng most of working life. DO NOT use reti		ness industry
5-0036 ed within 72 hours ed within 72 hours yygiene. other than "natu the Medical Exam Completed	10		Self - Employed		Improvement
21215-0036 uld be filed within 7 Mental Hygiene. marked other than e event, the Medica	17. Father's Name (First, Middle, Last)	L1+-		(First, Middle, Maiden Surname) Noelle Haggerty	7
2121() Ould be fil d Mental H s marked ite event,	Michael Edward Sc 19a. Informant's Name/Relationship (Type		ailing Address (Street and Number or F		
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 23s-f she injury or other traumatic event, the Medical Examiner must be notified at once To Be Completed by Funeral Director	Kelley N. Schultz	/ Mother 112	26 Reece Road Seve	rn, Maryland 211	L44
ore, se l an of Hea	20a. Method of Disposition 1 Burial 2 X Cremation 3		sposition (Name of cemetery, or other place)	Date 20c. Location - 0	City or Town, State
time t. Page timent resut:	4 Donation 5 Other Specify:		del Crematory 3-2 22. Name and Address of Facility	1-2012 Odento	n, Maryland
Ball permi Depar Impo	21. Signature of Funeral Service License	de colin	Donaldson Funeral 1411 Annapolis Ro	Home & Cremato	ry, P.A. vland 21113
Physician	23a. Pan I. Enter the disease, or complicate failure. List only one cause on each	ations that paused the death. Do not en	ter the mode of dying, such as cardiac of	r respiratory arrest, shock, or hear	t Approximate Interval Between Onset and
/Medicul	Immediate Cause (Final disease a. Ca	ardiac Arrhythmia			Death
	or condition resulting in death) Du	e to (or as a consequence of): Card ypertrophy and rip	liomegaly with left ht ventricular dil	t ventricular Latation	
ner		e to (or as a consequence of):			
ami i	(Disease or injury that initiated C.—	e to (or as a consequence of):			
be executed ician and urial - transit	d	AMENDED 23a-b, pt. II, 2	7 per me c030 8-1	5_12 cm	
			.7, рег ше, g, 50 0-1.	23d. Date of d	oliven
ox 68760 eath certificate attending phys for use as the brish	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy 1 Live birth 2	Fetal death 3 Ectopic pregna		Day Year
). Box 6876(i. the death certificate by the attending phy sched for use as the h Physician/Me	1 Yes 2 No 9 Unknown	Pregnant at time of death 5 9 Unknown	Other (Specify)		
9 - 9 -	Part II. Other significant conditions		he underlying cause given in Part I.	23e. Did tobacco use contribu	
s, P.C nires that signed d be det	Dandy Walker Synd	rome, status post	Intraventricular	1 Yes 2 ✓ No 3	
cords, aw requirent bas been a 2 should	shunt for hydroc	ephalus		autopsy pri	ere autopsy findings available or to completion of cause of ath?
tal Records, P.C. cian: The law requires that certificate has been signed ector, page 2 should be deat Be Completed by				1 ✓ Yes 2 No 1	Yes 2 No
Division of Vital Records, P.O. In or Attending Physician: The law requires that the safter death. In Director: After this certificate has been signed by led in by the funeral director, page 2 should be deach suffication: To Be Completed by P	25. Was case referred to medical examiner?	spital: 1 Inpatient 2 🗸 ER/Outpat	26.Place of Death (Check		Other:
n of Vi ding Physi After this funeral dir	1 Yes 2 No 27. Manner of Death	28a. Date of Injury (Month, Day, Year) 28b. Time		28d. Describe how injury occurred	1
ion trendir leath. tror: A	1 X Natural 5 Pending 2 Accident Investigation		1 Yes 2 No		
Division o spiral or Attending towns after death. neral Director: After filled in by the functor:	3 Suicide 6 Could not be	28e. Place of Injury - At home, farm, (Specify)	street, factory, office building, etc.	28f. Location (Street and Number or Town, State)	or Rural Route Number, City
Hours Junera	4 Homicide	: To the best of my knowledge, death o	ccurred at the time, date and place, and	due to the cause(s) and manner a	as stated.
Division To the Hospital or Attention Within 24 hours after death To the Funeral Director: completely filled in by the	one) 2 Medical Examiner: O	n the basis of examination and/or inves nd manner stated.	tigation, in my opinion, death occurred a	at the time, date and place, and du	e to the cause(s)
L FF . X	29b. Signature and title of certifier	0/10	29c. License number O.C.M.E.	29d. Date signed March 17, 26	(Month, Day, Year)
	30. Name and address of person who cor	moleted cause of death //tom 22a)	O.O.IVI.E.	Water 17, 20	
8) W. Baltimore Street, Baltimo	re, MD 21223	
State	MAILER CONTAC	32. P gistrar's Signature			
Registral		ORIGI	NAI		
DI IIVII I / NEV 1/2001	OGME	URIGI	1776		

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene State Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 20123:15 A^{M} DEBRA ANN STAMBAUGH March Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Frederick Frederick Memorial Hospital Frederick If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🕱 F Months Hours Min. (Month, Day, Yea Director 6 1960 Pennsylvania 212-72-5826 Usual Residence of Decedent 28a-f show 10a. State 10d. Inside City Limits 10b. County 10c. City, Town or Location ral", or items 23a or 28a-f sho Examiner must be notified at death with the Maryland Director 1 Yes 2 No Union Bridge Maryland Frederick 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 13133 Good Intent Road 21791 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian 11. Marital Status Armed Forces?

1 Yes 2 XNo Black, White, etc. 1 Never Married 2 Married ģ permit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examin Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 XNo Specify: Completed 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) secretary/office manager land development 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Dorothy Elizabeth Lawrence Charles V. Frock 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Union Bridge, MD 21791 Michael E. Stambaugh/husband 13133 Good Intent Rd. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Pipe Creek Cemetery 3/23/2012 4 Donation 5 Other (Specify) nr. Linwood, MD atul of Fureral Service Licensee 22. Name and Address of Facility Hartzler Funeral Home Union Bridge, MD 21791 6 E. Broadway 23a. Part 1. Enter the disease, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ var 7 an disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day Year 5 Other (specify) Month been signed by the should be detached g 🗌 Unknown Part II. <mark>Other significant condition</mark>s contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? Yes 2 No has certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical director, 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify, Hospital: 2 1 Tyes ER/Outpatient 3 DOA 1 🗶 Inpatient 2 🗌 within 24 hours after death. To the Funeral Director; After this Date of injury (Month, Day, Year) funeral Manner of Death Natural 28b. Time of Certificate: 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred injury 5 Pending Accident Investigation the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by 4 Homicide determined City or Town, State) Medical 29a. Certifier 🕽 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check the only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) acikova MDD 65443 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 400W Friderick State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day 2012 P M March 2:55 Paul Everett Smith Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Carroll Westminster Ridge Assisted Living Westminster 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) Mary Land 1 🖾 M 2 🗆 F Days (Month, Day, Hours Min. **Director** 215-20-7746 87 Usual Residence of Decedent show 10c. City. Town or Location must be notified at Director 10d. Inside City Limits 28a-f 1X Yes 2 No Maryland Carroll Westminster 10e. Street and Number 10f. Zip Code 2 10g. Citizen of What Country? Funeral 23a 507 High Acre Drive 21157 U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Examiner ed Forces? Yes 2 \(\sum \) No Black, White, etc. Completed by 1 X Never Married 2 ☐ Married ò XYes Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1943–46 1 ☐ Yes 2 X No Specify: Specify: "natural" 3 Widowed 4 Divorced White Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical once. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working banking/ life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 banker/asst. vice president commercial lending Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ William A. Smith Margaret M. Colleberry ge 1 and 2 should b nt of Health and Mer :: If item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Geraldine V. Miller/ niece Mechanicsburg, PA 17055 126 Victoria Dr. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place 1 🔀 Burial 2 🗌 Cremation 3 🗌 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 3/24/2012 Chapel Cemetery nr. Libertytown, MD 22. Name and Address of Facility Hartzler Funeral Home Signature of Funeral Service Licenses atharine New Windsor, MD 21776 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): -transit that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Year s been signed by the should be detached 1 ☐ Yes 2 ☐ 9 ☐ Unknown 9 Unknown P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 \square Yes 2 \square No 3 \square Probably 4 \square Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page 2 performed 1 ☐ Yes 2 ☐ No Yes 2 No Division of Vital 25. Was case referred to medica Be 26. Place of Death (Check only one) 2 L N Other: 1 Yes ျ this 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 X Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 28b. Time of Certificate: 28d. Describe how injury occurred Hospital or Attending Funeral Director: After Natural Pending 1 Tes 2 No Investigation Accident Suicide Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined

DHMH 17 Rev 7/2009

Registrar

State

To the

Medical

29a. Certifier

(Check

only one

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Ernesto Mendoza

MAR 2 6 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

826 Washington Rd., Ste. 120,

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

D0050763

29d. Date signed (Month, Day, Year)

22

Westminster, MD 21157

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Physician/ William EDWARD 0545AM SANK MAR 201 Medical 4a. Facility Name (if not Institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death HOWARD COUNTY COLUMBIA HOWARD COUNTY GENERAL HOSPITAI If Under 1 Year If Under 24 Hrs. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours 68 212-42-1703 4/16/1943 Maryland **Director** Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director notified 28a-f Sykesville 1 Yes 2 No Maryland Howard 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? ms 23a or must be r Funeral 01d Frederick Road 13079 U.S.A. 21784 er than "natural", or items the Medical Examiner mu 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, rmed Forces?
Yes 2 No If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. ģ 1 Never Married 2X Married If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: Specify: Completed 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) than Elementary/Seconday (0-12) College (1-4 or 5+) MMATA Main Supervisor other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) alth and Mental F 27 is marked of traumatic ever Mary K. Pfeffer မ William E. Sank, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Health (item 27 Old Frederick Road Sykesville, MD 21784 Joan L. Sank / Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or ott once. Date cemetery, crematory or other place) 1 ☐ Burial 2 💆 Cremation 3 ☐ Removal from State 3/26/2012 Towson, Maryland 4 Donation 5 Other (Specify) Hilltop Serv. Corp. 21. Signature of Fundral Say 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ LEUKEMIA disease or condition resulting in death) ACUTE Medical Due to (or as a consequence of) **Examiner** RESPIRATORY FAILURE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or iinjury that initiated events resulting in death) Last PNEUMONIA attending physician and for use as the burial-tran Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ PERICARDIAL EFFUSION 1 Tes 2 Tho 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? DIABETES MELLIUS 24a Was an page 2 performed' CHRONIC OBSTRUCTIV PULMONARY DISEASE 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner?
1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined

the Hospital or Attending Physician: The law requires that the death certificate be executed P.O. Box 68760 Division of Vital Records, 24 hours after death. Funeral Director: After this within 24 hours after de

To the Funeral Directo

completed filled in by th

Page 1 and 2 should be filed within 72 hours after death

Baltimore, Maryland 21215-0036

State

Medical

(Check only one 29b. Signature and title of certifie

Mythilly

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MYTHILY VANCHA

MD

11085 Little Pataxent PKWY, Swite Lool, Columbia, MD 21044 31. Date filed (Month, Day, Year) MAR 2 6 2012

Registrar

Ecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

D0064760

29d. Date signed (Month, Day, Year)

MAR, 24, 2012

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ March Medical 4a. Facility Name (if not institution, give street and number) City, Town, or Location of Death 4c. County of Death **Examiner** JOSY LONG 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign vrs. last birthday) Funeral Months Hours Min 57 Director 1 M 2 W F MD 06/22/ 10d. Inside City Limits 10b. County must be notified at 10a. State 10c. City, Town or Location Director 28a-f 1 ☐ Yes 2**X** No Randallstown Baltimore MD 10f. Zip Code 10e. Street and Numbe 10g. Citizen of What Country? 0 23a 21133 U.S.A. 3720 Tall Grass items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14 Bace - American Indian. Examiner Armed Forces? Black, White, etc. o 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 XNo Specify: Specify: Black "natural", 3 Widowed 4 Divorced Completed traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Je filed wru. Hal Hygiene. Ser than "r Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 5yrs+ Elementary/Secondary (0-12) State of Maryland Clinical Psychologist 12th grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) th and Mental F Mattie Lee Walker ပ္ William H. Steward 1 and 2 should to the street and Me item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 924 Wilton Dr., Baltimore, Md 21227 William Steward-Brother 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State Department of Important: If it any injury or o once. 1 Burial 2 Cremation 3 Removal from State ing Memorial Park 3/24/2012 Woodlawn, Md Donation 5 Other (Specify) 21. Signa f Funeral Service Licensee March F/H West 21215 4300 Wabash Ave, Baltimore, Md 23a. Part . Enter the disease, or complications that car shock, or heart failure. List only one cause on each ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nterval Between Onset and Death Immediate Cause (Final Physician/ arythemias disease or condition resulting in death) Cardiac 10 minutes Medical Due to (or as a consequence of): Examiner e years Non ischemic Cardiomyopethy Sequentially list conditions, Examiner rany, reading to immediate cause. Enter Underlying Cause (Disease or injury Due to for se a consequence of 5 years Hypertension as the burial-trar and that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical requires that the death certificate be Box 68760 nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 1 ☐ Yes 2 ☐ g ☐ Unknown by the Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Division of Vital Records, Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an ate has t autopsy performed 1 Yes 2 No 1 ☐ Yes 2 🗷 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital 2 No Other: 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) ဂ္ Director: After this 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: (Month, Day, Year) injury work?
1 Yes 2 No 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) To the Hospital within 24 hours a To the Funeral D Medical 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Dav. Year) K DUS AIMO D30494 3/21/2012 les a

DHMH 17 Rev 06-2011

State Registrar DESAIMD 716 maiden Choicelane 202 Baltimore MD 21228

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 03 Physician/ Day Skinner 2012 Lee 16 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Future Care Nursing If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** (Month, Day, Year) Days Hours **Director** 83 250-56-9537 1 M 2 X F 29 02 24 show 10a. State 10b. County 10c, City, Town or Location should be filed within 72 hours after death with the Maryland at Director "natural", or items 23a or 28a-f s idical Examiner must be notified Baltimore NA MD 10e. Street and Number 10g. Citizen of What Country? U.S.A. Funeral 21201 1100 Pennsylvania Ave #515 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status 14. Race - American Indian, Armed Forces? 1 ☐ Yes 2 🛣 No Black, White, etc. þ 1 \square Never Married 2 \square Married 21215-0036 Specify: Black 1 ☐ Yes 2 🔀 No Specify: If Yes, Give 3

▼ Widowed 4 □ Divorced Completed Year or Dates. event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Franklin Court and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Nursing Center Supervisor <u>llth grade</u> na Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Carrie Grate Sinnie Grate e 1 and 2 should be of Health and Ments if item 27 is marked r other traumatic e 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1826 Riggs Ave, Baltimore, Md 21217 Phyllis Gause-Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Page 1 / Department of H Important: If ite any injury or ot Date cemetery, crematory or other place) X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 3/21/2012 Woodlawn, Md Kina Memorial Park ature of Auneral Service Licensee March for fiver of Wells t 6, 4300 Wabash Ave, Baltimore, 3a. Part. Enter the disease, or complications that coursed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, speck, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ ATHEROSELEROTIC HEART disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Ecquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Exami and that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?

1 Yes 2 No

9 Unknown Month Pregnant at time of death q 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by DNEUMONIA 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown GASTRIC CANCER 24a. Was an METASTATIC autonsy

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 filled in by the funeral director, page 2 should within 24 hours after death **To the Funeral Director**:

25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 2 **X** No Other: Yes e 5 Residence 6 Other (Specify)

24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No ☐ Yes 2 🗙 No

3. Time of Death

10d. Inside City Limits

1 Yes 2 No

04:38

SC

21215

Day

Year

Interval Between Onset and Death

YEARS

1 = 100 = 7.10	1 Inpatient 2 ER/Outpatient 3 I DOA 4 Nursing F	ome 5 □ Residence 6 □ Other
27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	28a. Date of injury (Month, Day, Year) 28b. Time of injury 28c. Injury at work? 1 □ Yes 2 □ No	28d. Describe how injury occurred
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number City or Town, State)

f. Location (Street and Number or Rural Route Number

29a	Certifier (Check		Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner		
	only one)	3	Certifying Nurse Practitioner: To the best of my knowledge, death	occurred at the time, date and place, and due to	the cause(s) and manner as stated.
29b.	Signature ar	ditl	e of pertifier	29c. License number	29d. Date signed (Month, Day, Year)

	► (h Vasanthakumas	D
Į	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	

MARCH 21, 2012 M. VASANTHA KUMAR MD, 516-N. ROLLINGRD # 108, MD 21228

State Registrar

Be (

မှ

Certificate:

Medical

31. Date filed (Month, Day, Year)



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

	1- For State Registrer Certificate of Death Reg. No. 2012 0928
Physician/ Medical Examiner	
	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death
Funeral	Carroll Hospital Center Westminster Carroll 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or
Director	218-78-1627 Months Days Hours Min. Feb 23 1964 Foreign Country)MD
ku w	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits
Maryland 28a-f show 1 at once. ector	MD Carroll Marriottsville 1 Tyes 2 No
r death with the Maryland or items 23a or 28a-f sho must be notified at once. Funeral Director	10e. Street and Number 7118 Shalin Drive 10f. Zip Code 21104 10g. Citizen of What Country? USA
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 37 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once To Be Completed by Funeral Director	11. Marital Status 1 Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 1992 1 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc.
urs afte tural", aminer	45 December 5 description (Separate and a completed) 145 December 150 Civil bind of work does 145 Mind of Project Mind of Project Mind of Project Mind of Project Mind of Project Mind of Project Mind of Project Mind of Project Mind of Project Mind of Project Mind of Project Mind of Project Mind of Project Mind of Project Mind of Project Mind of Project Mind of Project Mind of Project Mind of Project Mind of Project Mind of Project Mind of Project Mind of Project Mind of Project Mind of Project Mind of Project Mind of Project Mind of Project Mind of Project Mind of Project Mind of Project Mind of Project Mind of Project Mind of Project Mind of Project Mind of Project Mind of Project Mind of Project Mind of Project Mind of Project Mind of Project Mind of Project Mind of Project Mind of Project Mind of Project Mind of Project Mind of Project Mind of Project Mind of Project Mind of Project Mind of Project Mind of Project Mind of Project Mind of Mind of Project Mind of Mind of Mind of Mind of Mind of Mind of Mind of Mind of Mind of Mind of Mind of Mind of Mind of Mind of Mind of Mind of Mind of Mind of Mind of Mind of Mind of Mind of Mind of Mind of Mind of Mind of Mind of Mind of Mind of Mind of Mind of Mind of Mind of Mind of Mind of Mind of Mind of Mind of Mind of Mind of Mind of Mind of Mind of Mind of Mind of Mind of Mind of Mind of Mind of Mind of Mind of Mind of Mind of Mind of Mind of Mind of Mind of Mind of Mind of Mind of Mind of Mind of Mind of Mind of Mind of Mind of Mind of Mind of Mind of Mind of Mind of Mind of Mind of Mind of Mind of Mind of Mind of Mind of Mind of Mind of Mind of Mind of Mind of Mind of Mind of Mind of Mind of Mind of Mind of Mind of Mind of Mind of Mind of Mind of Mind of Mind of Mind of Mind of Mind of Mind of Mind of Mind of Mind of Mind of Mind of Mind of Mind of Mind of Mind of Mind of Mind of Mind of Mind of Mind of Mind of Mind of Mind of Mind of Mind of Mind of Mind of Mind of Mind of Mind of Mind of Mind of Mind of Mind of Mind of Mind of Mind of Mind of Mind of Mind of Mind
2 21215-0036 bould be filed within 72 hours a: nd Mental Hygiene. is marked other than "natural ntic event, the Medical Examin TO Be Completed by	Elementary/Secondary (0-12) College (1-4 or 5+) 8 College (1-4 or 5+) Comptroller United Crane
5-00 ed with Hygiene other 1	17. Father's Name (First, Middle, Lest) 18.Mother's Name (First, Middle, Maiden Surname)
d be fill fental I family or went, I Be	Catherine May Pita
MD 21215-0036 12 should be filed within 7 th and Mental Hygiene. 127 is marked other than umatic event, the Medica To Be Comple	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7118 Shalin Dr., Marriottsville, MD 21104
ore, I and of Healt If item	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State
Baltimore, pernit. Pages I an Department of Hea Important: If itee injury or other tr	Springfield Cemetery 3-22-12 Sykesville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of FacilityHaight Funeral Home & Chapel
Ba Dem Depa Inju	P.O. Box 195 Sykesville, MD 21784
Physician /Medical	23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Compliance Approximate Interval Between Onset and Death
Examiner	Immediate Cause (Final disease or condition resulting in death) a Cardiac Arrhythmia Due to (or as a consequence of):
-	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):
ted Insit Examine	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):
tO, e be executed ysician and burial - transit	dd
60, ate be execu hysician and burial - tra Medical	■ MENDED 23a-b,27,per me,g925 3-29-12 sm
6876 ertificat ding phy e as the	IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 23d. Date of delivery Month Day Year
h. Box 687 the death certific by the attending I ched for use as th	1 Yes 2 No 9 Unknown Unknown Unknown
P.O. I s that the med by the detache	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 V Unknown
ords, F w requires s been sign should be	24a. Was an 124b. Were autopsy findings available
Records, The law requires ficate has been sig page 2 should be Completed	autopsy prior to completion of cause of performed? 1 ✓ Yes 2 No 1 ✓ Yes 2 No
tal Recition: The certificate rector, page	25. Was case referred to medical 26.Place of Death (Check only one)
of Vit ng Physic After this of an eral dire	examiner? 1 Ves 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred
ion c tending eath. tor: Af the fun	1 X Natural 5 Pending 2 Accident Investigation (Month, Day, Year) 1 Yes 2 No
Division of Vital Records, P.O. sepital or Attending Physician: The law requires that thours after death. Ineral Director: After this certificate has been signed by a filled in by the funeral director, page 2 should be deate. Certification: To Be Completed by F.	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)
Hos Fun Fun	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. One) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
To the within To the complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex complex c	and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)
	Carol Hallan O.C.M.E. March 18, 2012
Dent	30. Name and address of person who completed cause of death (Item 23a) Carol Allan, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223
State Registrar	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1 Decedent's Name (First Middle Last 2. Date of Death 3. Time of Death Physician/ MARCH 2012 VERONICA FANTA SOWA 10:02 A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 14104 WISPERING PINES COURT #34 SILVER SPRING MONTGOMERY If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days **Director** 211-89-0611 1 M 2X F 62 JAN 1 1950 SIERRA LEONE Usual Residence of Decedent 28a-f show 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits Director must be notified MD MONTGOMERY SILVER SPRING 1 X Yes 2 No 5 10e. Street and Number 10f. Zip Code 10q. Citizen of What Country? 23a Funeral 14104 WISPERING PINES COURT #34 20906 SIERRA LEONE 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, Examiner Armed Force Black, White, etc 0 1 Never Married 2 Married ð 1 Yes 2 No Baltimore, Maryland 21215-0036 1 Tes 2 To No Specify "natural" Specify: BLACK 3 Widowed 4 Divorced Completed Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done of life. DO NOT use retired) during most of working Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) the 12TH HEALTH ADMINISTRATOR GOVERNMENT Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be fill Department of Health and Mental Important; If item 27 is marked မ AMADU SESAY BAINDU SANNOH 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20906 19a. Informant's Name/Relationship (Type, Print) JUSTIN SOWA/HUSBAND 14104 WISPERING PINES COURT #34 SILVER SPRING, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State injury or GATE OF HEAVEN 4/21/2012 SILVER SPRING, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) J.B. JENKINS FUNERAL HOME, INC. 22. Name and Address of Facility any 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ ENDOMETRIAL CARCINOMA disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examine if any, leading to immediate cause. Litter Underlying Cause (Disease or injury Due to (or as a consequence of) The law requires that the death certificate be executed burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): physician s the buria Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Dav Pregnant at time of death 1 Yes 2 x 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24a. Was an Were autopsy findings available Jas prior to completion of cause of page death? 2**X** No 1 Nes ☐ Yes Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other 2 X No ည 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Kesidence 6 Other (Specify) eral Director: After thi filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending 1x Natural 5 Pending iniury work? 1 ☐ Yes 2 ☐ No death. Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined City or Town, State, 24 hours Medical 29a. Certifier 🖾 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature 29c. License number 29d. Date signed (Month. Day, Year) 6

Registrar DHMH 17 Rev 06-2011

State

5454 WISCONSIN AVENUE #1300 CHEVY CHASE, MARYLAND 20815

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NELSON KALIL M.D.

MAR 26

Year,

31. Date filed (Month,

MARCH 21, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

State

Registrar

DR Marc

31. Date filed (Month, Day, Year)

Christophe

Smith

4000 FRANKLIN Square DR Balto Md

2012

2123

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

casasanTa

MAR 2 6 2012

			State of Maryland / Dep 1 - State Amend Item 25 per me, g925,03/21	artment of Health and Me 12012dhb Tificate of Death	ental Hygie Reg.	ne No. 2 ()	2 19289
	Physicia		1. Decedent's Name (First, Middle, Last) ROBYN P. VICK		2. Date of Death Month	Day Year	3. Time of Death 2 45 PM
*	Medic Examin		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	02	4c. County of Dea	
أمريت	<i>)</i>		GOOD SAMARITAN HOSPITAL	BALTIMORE		BALTIMO	
	Funeral Director		5. Social Security Number 6. Sex 1 M 2 M F 7. Age (In yrs. last birthday) 5 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yea 29 1	9. B	irthplace (State or Foreign ountry)
100	-		Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Lo		02 21		
	aryland a-f sh fied a	Director	10a. State 10b. County 10c. City, Town or Lo				10d. Inside City Limits 1 Yes 2 □ No
	the Ma or 28 e noti		10e. Street and Number	10f. Zip Code	10g.	. Citizen of What C	Country?
	h with	Funeral	3922 Dudley Ave.	21213		USA	
.	or iten	by Fu	11. Marital Status 1	Was Decedent of Hispanic Origin? (Speci If Yes, specify Cuban, Mexican, Puerto Ri	fy Yes or No- can, etc.)	14. Race - Am Black, Whi	
21215-0036	within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at		3 Widowed 4 Divorced If Yes, Give Year or Dates.	1 ☐ Yes 2 🕱 No Specify:		Specify: \mathcal{B}_l	lack
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212	within giene. er tha		Flementary/Seconday (U=12) College (1-4 or 5±)	2/25	5	ears 0	utlet
	e filed ital Hy ed oth event	To Be	17. Father's Name (First, Middle, Last)	18. Mother's Name	First, Middle, Maid	len Sumame)	
Maryland	should be fil and Mental is marked aumatic ev		19a. Informant's Name/Relationship (Type, Print) 19b. Maili	ng Address (Street and Number or Rural		lliams	
_	1 and 2 should be f Health and Men item 27 is marke other traumatic		Kelli Vick- Sister 392	2 Dudley Ave.	Λ · · ·		
Baltimore,			20a. Method of Disposition 20b. Place of Dispo	osition (Name of Da matory or other place)	ite 20d	c. Location - City o	or Town, State
Him	t. Pag tmen rtant:		4 Donation 5 Other (Specify)		2012 E	Battimos	-c, MD
Ba	Depar Impor any ir		21. Signature of Funeral Service Lipensee	3 11 1	21202	354 1101 E	. North Ave.
H	HOL		23a. Part 1. Enter the disease, or complications that caused the death. Do not ent shock, or heart failure. List only one cause on each line.	/ / / / / / / / / / / / / / / / / / / /			Approximate Interval Between
in the same	Physician/ Medical		Immediate Cause (Final disease or condition resulting in death)	(RE			Onset and Death
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	te be executed hysician and he burial-transit	Examine	Cause (Disease or linjury that initiated events resulting in death) Last c. Due to (or as a consequence of):	0	PPROVED BY MEDIC	AL EXAMINER	
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3876	rtificat ling ph e as th	/Mec	IF FEMALE:	CEVIA			
Box 68760	attend for us	cian	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ 4 ☐ Pregnant at time of death 5 ☐	Ectopic pregnancy Other (specify)		23d. Date of d Month	elivery Day Year
O. B	the de by the ached	Physician/Medical	9 Unknown 9 Unknown				
, P.O.	v requires that the death certificat been signed by the attending ph should be detached for use as th	ğ	Part II. Other significant conditions contributing to death but not resulting in the a AUTE KIDNEY INTURY.	underlying cause given in Part I.			to the cause of death? Probably 4 Unknown
ords	requir been s should	Completed	Trail Fibroit Ingasi		24a. Was an		utopsy findings available
3ec	he law te has age 2	dwo			autopsy performed 1 Yes 2	prior to death?	completion of cause of
E F	ctor, p	Be C	25. Was case referred to medical examiner?	26. Place of Death (Check of			55 Z = NO
Ţ	Physic this c	은	examiner? 1	, 1	e 5 Residence		ecify)
o uc	nding ath. r: After re fune	icate	1 Matural 5 ☐ Pending (Month, Ďay, Year) injury 2 ☐ Accident Investigation	work? M	d. Describe now in	ijury occurred	
Division of Vital Records,	or Atte fter de virecto n by th	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm, str building, etc. (Specify)	reet, factory, office	3f. Location (Street City or Town, St		ural Route Number,
۵	To the Hospital or Attending Physician: The law requires that the death certifical within 24 hours affer death. To thin 24 hours affer death. To thin Funeral Director. After this certificate has been signed by the attending prompleted filled in by the funeral director, page 2 should be detached for use as the completed filled in by the funeral director, page 2 should be detached for use as the completed filled in by the funeral director, page 2 should be detached for use as the completed filled in by the funeral director, page 2 should be detached for use as the completed filled in by the funeral director, page 2 should be detached for use as the completed filled in by the funeral director.		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death	occured at the time, date and place, and	due to the cause(s	s) and manner as s	tated.
	the Ho nin 24 h the Fur npletec	Medical	(Check 2 ☐ Medical Examiner: On the basis of examination and/or investonly one) 3 ☐ Certifying Nurse Practioner: To the best of my knowledge,	stigation, in my opinion, death occurred at the	ne time, date and pl	ace, and due to the	cause(s) and manner stated.
	S S S S		29b. Signature and title of certifier	29c. License number	29d.	Date signed (Mon	
	(1)		30. Name and address of person who completed cause of death (Item 23a) (Type, I			BALTIME	DEG MO .
			LORI-AVN FUHER GOOD SAMARITHN F 31. Date filed (Month, Day, Year) 32. Registrar's Signature	tospitml 560lloch R	AVGN BLI	10 2	21829
	Stat Registra	ar ar	MADOGOOGO K	Kal			
			1000				

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 20 2017 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death Examiner Baltimore Good Samaritan If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Numbe **Funeral** 1□M 2XF 31, 1937 Maryland 74 Director 218**-**34-0360 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County 28a-f show iral", or items 23a or 28a-f shov Examiner must be notifled at 1 ☐ Yes 2 No Director Millsboro DE Sussex 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with 19966 USA 138 Teal Drive Completed by Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2X If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: white 3 Widowed 4 Divorced "natural", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 72 hc Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the MedicaL. 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Lucent Technologies 12 Manager 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Katherine Shaw Fielder Hiss 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Fielder Hiss, Jr. / brother 315 Black Bear Run; Stowe, VT 05672 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2XC emation 3 ☐ Removal from State Hilltop Service Corp. 3/22/2012 Towson, MD 4 Donation 5 Dother (Specific 22. Name and Address of Facility 1050 York Road 21. Signature of Fyneral Sa Towson, MD 21204 Ruck Towson Funeral Home, Inc. aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part1. Enter the disease, or complications that shock, or heart failure. List only one cause Onset and Death Immediate Cause (Final SERSIS **Physician** disease or condition resulting in death) /Medical Due to (or as a cons quence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner sician and burial-transit Due to (or as a consequence of) Physician/Medical INTHOSE attending pl 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Day in the past 12 months?
1 Yes 2 No
9 Unknown Month Year 4□Pregnant at time of death 5 Other (specify) 9☐Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an his certificate has director, page 2 a autopsy performed No 2 No 1 🗌 Yes 25. Was case referred to medical examiner? 26. Place of Death Check on one) Be No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Inpatient 1 ☐ Yes 2 ER/Outpatient 3□ DOA this 28d. Describe how injury occurred 27. Manner of Death 28a Date of Injury 28b. Time of 28c. Injury at Work? (Month, Day Year) Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No

Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, funeral After hin 24 hours after death.

the Funeral Director: A

npletely filled in by the fu within 2

Medical Certification: To 3 ☐ Suicide 4 Homicide 29a, Certifier (Check only one)

29b. Signature and title of certifier

State Registrar 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6 ☐ Could not be

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

31. Date filed (Month, Day, Year)

MAR 2 6

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day March 23, Physician/ Mabel Walkemeyer 2012 Year Αм 7:30 Medical 4a. Facility Name (if not institution, give street and number) 4h City Town or Location of Death 4c. County of Death **Examiner** Lighthouse Senior Living Essex Baltimore Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year **Funeral** Days Hours 215 16 2934 93 **Director** 1 M 2 XF Sept. 16, 1918 Yrs Maryland Usual Residence of Decedent 28a-f shov 10a. State 10b County 10d. Inside City Limits notified at 10c. City. Town or Location Director Baltimore Maryland Essex 1 Yes 2 X No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? must be 23a Funeral 1748 Hilltop Avenue 21221 USA items death v 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Examiner Black, White, etc o þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 hours after If Yes, Give Year or Dates 1 Yes 2 No Specify. Specify: White "natural", Completed 3 XWidowed 4 Divorced Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumation. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James Edward Fischer Alma Eleanor Bookhultz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ellen Walters (Daughter) 1748 Hilltop Avenue Essex, Maryland 21221 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🗷 Burial 2 🗆 Cremation 3 🗆 Removal from State Edgewood Memorial Park 3/26/2012 4 ☐ Donation 5 ☐ Other (Specify) Glen Mills, Pennsylvania Signature of Funeral Service License 22. Name and Address of Facility Bruzdzinski Funeral Home P.A. 1407 Old Eastern Avenue Essex, Maryland 21221 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final - hysician/ disease or condition resulting in death) woha uea, Medical Due to (or as a consequence of Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) ician and burial-trans that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical phys. Division of Vital Records, P.O. Box 68760 as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 C Ectopic pregnancy
5 Other (specify) in the past 12 months? jo Pregnant at time of death 2 X No Unknown g 🗌 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has page certificate 2 X No 2 🗌 No 1 Yes Yes Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital ASSISKA LIVIR 1 ☐ Yes 2 🔀 No After this o မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Nother (Specific 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending injury work? 1 🗌 Yes 2 🗌 No 1 🛚 Natural 5 Pending after death.

Director: Aft
d in by the fu Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the 1 29b. Signature and title of certifie 29c. License number 29d, Date signed (Month, Day, Year) completed cause of death (Item 23a) (Type, Print) 30. Name and address of person who

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 25,27,28a-f per me, g925,03/21/2012dhb
Registrar

Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Washington Woolford 2012 7:01AM 3 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 0380 Olumbia toward Tainted If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number **Funeral** vrs. last birthday) Months Days Hours Min Country) 220-24-0425 1930 Director 28a-f show Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10d. Inside City Limits 10c. City Town or Location Director MD 1 Yes 2 No mbia Howard 10f. Zip Code 10e. Street and Numb 10g. Citizen of What Country? Funeral 10380 21044 USA rainted Page 1 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Yes 2 No Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Specify: Black 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) -College (1-4 or 5+) Diovernment tedera Be 17. Fara's Name (First Middle, Last) Mother's Name (First, Woolford ည 19b. Mailing Address (Street and Numb State, Zip Code) 0380 rainted olumbia, 20b. Place of Disposition (Name of cemetery, crematory or other to 20a. Method of Disposition Cemetery, cremetory or other Dumbia Memoria **☑** Burial 2 ☐ Cremation 3 ☐ Removal from State 29-2012 4 Donation 5 Other (Specify) lark 21. Signature of Furieral Service License Van 23a. Part 1. Ent the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Preumonia Immediate Cause (Final Physician/ month disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner month piration Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): AnoxIL Brain physician and s the burial-trans Due to (or as a consequence of): resulting in death) Last PPROVED BY WED Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be a within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicia completed filled in by the funeral director, page 2 should be detached for use as the burn Division of Vital Records, P.O. Box 68760 CERTIFICAT IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Live Birth 2 Fetal deat
Pregnant at time of death
Unknown in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by tracheotomy 1 🗌 Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an nalnatrition autopsy performed? death? 2 🔄 No Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident work? 1 ☐ Yes 2 **X** No 5 Pending Subject was dropped Unknown Unknown Investigation 3 ☐ Sulcide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Nursing Home 28f. Location (Street and Number or Rural Route Number, City or Town, State) 9101 2nd Avenue Silver Spring, MD determined Medical Ecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one)

State

Registrar

29b, Signature and title

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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32. Registrar's Signature

Marylon

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day} 20<u>12</u> March 13 Physician/ Wallen 5:35 P^M Trvin Eugene Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Montgomery Montgomery General Hospital 01ney If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year, 720-18-2027 Director 1 X M 2 □ F 0klahoma 90 Oct. 4, 1921 Usual Residence of Decedent r 28a-f show notified at 10d. Inside City Limits 10a. State 10c. City. Town or Location Director 1X Yes 2 No Maryland 01ney Montgomery 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 9 items 23a or ner must be n Funeral 20832 U.S.A. 18208 Bluebell Lane Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status an "natural", or iter Medical Examiner rmed Forces?

X Yes 2 \(\sum \) No Black White etc 1 Never Married 2 Married þ within 72 hours after Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates ^{Speci}American Indian 3 ₺ Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business/Industry and Mental Hygiene. is marked other than life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) the Research Scientist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ t. Page 1 and 2 should be tment of Health and Men tant: If item 27 is marke Stuvie C. Wallen Mittie Hames 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 18208 Bluebell La., Olney, MD 20832 Mark Wallen (Son) other altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Salem Lutheran Cemetery 3/19/2012 1 X Burial & ☐ Cremation 3 ☐ Removal from State injury or Department Important: If any injury or Stillwater, OK ponation 5 Other (Specify) 22 Name and Address of Facility Metropolitan Funeral Service 5517 Vine St., Alexandria, VA 22310 eral Service Licer 21. Sign ture of Fu 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final -Pnysician/ Dirator. العا disease or condition Medical resulting in death) Due to (or as a consequence Examiner Sequentially list conditions Examine sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last attending physician and I for use as the burial-transit asophari Due to (or as a consequence of Physician/Medical certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? The law requires that the death Month 5 Other (specify) Day Pregnant at time of death the signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an has autopsy page 2 To the Hospital or Attending Physician; The within 24 hours after death.

To the Funeral Director; After this certificate I Yes 2 No filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ည 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 Natural iniun 5 Pending ☐ Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 ☐ Homicide 28f. Location (Street and Number or Rural Route Number. determined City or Town, State) Medical

completely

29a. Certifier

only one)

29b. Signature and title of certifier

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32. Registra State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

DOOG 7976

29d. Date signed (Month. Day, Year)

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18101 PrincePhillip Dr., Olney, MD 20832

29c. License number

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State of Maryland / Department of Health and Mental Hygiene
Cartificate of Death

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Funeral Director				7. Age (In yrs.	last birthda	y) If Un Mon	ths Days	If Under 2			(MM/DD/YYYY)	Enraign	
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Baltimore, MC permit. Pages 1 and 2 s Department of Health an Important: If item 27 injury or other trauma		20a. Method of Disposition		20b.	Place of Di	isposition (N	ame of cem	etery,	Date	,	20c. Location - 6	City or Town	n, State
Baltimore, permit. Pages 1 as Department of He Important: If ite		1 Burial 2 Cremation	_			or other place	lemor	ial	/20 /	2012	Dinala		NIV
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/Medical Examiner		Immediate Cause (Final disease	a. Hyperte	nsive A	Ather	oscler	otic	Cardi	ovasc	ular	Disease		Death
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Box 68760, e death certificate be the attending physical for use as the but	M	IF FEMALE: 23b. Was decedent pregnant in the		utcome of preg rth	nancy 2	Fetal deatl	n 3 [Ectopic pr	egnancy		23d. Date of d Month	lelivery Day	Year
th cerr	icia	past 12 months?	1	ant at time of de		Other (Sp	ecify)					•	
B B B B B B B B B B B B B B B B B B B	Physician/Me	1 Yes 2 No 9 Unkn	90/1/6/100								<u> </u>		
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Division To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical	(Check only Certifying Pily	rsician: To the best iner:On the basis of	f examination a	7								se(s)
Som Som	Med	29b. Signature and title of certifier	and manner sta	ated.		29	c. License	number		T	29d. Date signed	(Month, D	ay, Year)
	-1	1/1/					O.C.M	.E.		- 1	March 20, 20		·
		30. Name and address of person w	no completed carrs	e of death (Item	/ 1 23a)								
		Russell Alexander MD.	Assistant Me	-		00 W. Ba	Itimore S	Street, Ba	altimore,	MD 212	23		
St	ate	31. Date filed (Month, Dav Year)	32. Aeç	gistrar's Signatu		-							
Regist		MADOR	2012 am	me 2	1. 1	arket							

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month_ Physician/ Warehime Glenda Lind Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll Hospital Center Westminster Carrol] If Under 1 Year If Under 24 Hrs Hours Min Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Social Security Number (Month, Day, Year) Davs 1 □ M 2 🔀 F Months Director 190-36-7944 67 Feb 28. 1945 Pennsylvania Usual Residence of Decedent 10c. City, Town or Location 10b. County 10a. State the Maryland Director ms 23a or 28a-f s must be notified 1 X Yes 2 No Maryland New Windsor Carrol] 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral within 72 hours after death with 21776 109 Springdale Ave. U.S.A items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) ı "natural", or item edical Examiner m 12. Was Decedent Ever in U.S. Armed Forces? 14 Bace - American Indian. 11. Marital Status Black, White, etc. by 1 Never Married 2 Married Yes 2 X No Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: White 3 Widowed 4 Divorced Completed Year or Dates other than "naturent" 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education Give kind of work done during most of working (Specify only highest grade completed) life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. teacher public school 5+ Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) is marked ဂ Glenn A. Freil Emma Jean Cowan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 Ronald E. Warehime/husband New Windsor. MD 21776 other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite 1 X Burial 2 Cremation 3 Removal from State injury or 4 ☐ Donation 5 ☐ Other (Specify) 3/23/2012 nr. Linwood, MD Pipe Creek Cemetery 21. Sign free f Fundral Service, License 22. Name and Address of Facility Hartzler Funeral Home 310 Church St. New Windsor, MD 21776 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between ASPIRATION PNEUMONIA Onset and Death Immediate Cause (Final Ph_sician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** BOWEL SMALL OBSTRUCTUON Secure tielly list conditions if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or iinjury that initiated events requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 attending physical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months2 Day 5 Other (specify) Pregnant at time of death signed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Tes 2 No 3 □ Probably 4 □ Unknown cate has been sig page 2 should b 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No Hospital or Attending Physician: The law certificate ! 1 ☐ Yes 2 ⊡ No 26. Place of Death (Check only one) 25. Was case referred to medical Be Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 2 No 1 TYes 1 Inpatient 2 ER/Outpatient 3 DCA မ After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending work' 1 ☐ Yes 2 ☐ No death. Accident Suicide Investigation 24 hours after death Funeral Director: the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I 29d Date signed (Month, Day, Year, 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

FRANCIS KHOO, MD ZOO MEMORIAL AVE, WESTMINSTER,

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

			For Amend	l Items 2	State of M	aryland f h,g 9	25 Dep 25 , 03/ Cer	rtment of L 26/2012dt tificate of L	lealth I b Death	and M	lental Hy	giene Reg. No. "	2012	00296
			Decedent's Name								2. Date of De	d.	U I É	3. Time of Death
	Physicia Medic		Otto D	ale Wilk:	inson		_				Menth	8	2 010	7 0415M
0	Examin		4a. Facility Name (if Western M		street and number) Health Sys	stem		4b. City, Town, or Cumberla		of Death		4c. Co A1	ounty of Death legany	1
	Funeral		5. Social Security N			je (In yrs. la	st birthday)	If Under 1 Year Months Days	If Under Hours	r 24 Hrs. Min.	8. Date of Bi			hplace (State or Foreign
	Director		236-20-63	13	XM 2 □ F 9	1	Yrs.	Months	Tiodro		Nov. 8			kton,Co. WV
	nd how at		Usual Residence of 10a. State	10b. County		10c. City	, Town or Loc	ation	<u></u>					10d. Inside City Limits
	faryla 3a-f s iffied	Director	WV	Hampshi:	re	Ron	nney							1 ☐ Yes 2 🛣 No
	or 28		10e. Street and Nur	nber				10f. Zip Code				10g. Citize	n of What Co	untry?
	s 23a	Funeral	Foxes Ho	11ow, HC	65, Box 4	4430		26757				USA		
	72 hours after death with the Maryland n"natural", or items 23a or 28a-f show fledical Examiner must be notified at		11. Marital Status	ied 2 Married	12. Was Decedent Armed Forces?		1:	Vas Decedent of Hi Yes, specify Cuba	spanic Or n, Mexica	rigin? (Spe in, Puerto	cify Yes or No Rican, etc.)	- 14	. Race - Amer Black, White	
21215-0036	s after al", o Exam	d by	3 Widowed		1 Yes 2 If Yes, Give Year or Dates.	™1940 1960	0 -	☐ Yes 2 🔀 No	Specify	<i>/</i> :		Sp	ecify: Whi	te
0-0	hours natur	lete	(Spe	15. Decedent's E	ducation		16a. Deced	lent's Usual Occupa	ation	st of worki	na		of Business/	
21	1 and 2 should be filed within 72 hour if Health and Mental Hygiene. item 27 is marked other than "natu other traumatic event, the Medical	Completed	Elementary/Second		College (1-4 or	5+)	life. D	O NOT use retired)			9	116	Nazzz	
	filed within tal Hygiene. d other than event, the M	Be C	17. Father's Name (First Middle Last)	5+	i	Chier	Petty Of			e (First, Middle		Navy	
Maryland	should be filed within 7; and Mental Hygiene. is marked other than aumatic event, the Me	To		11kinson							ea Cuti		,,,,,,,	
aryl	should be file and Mental I is marked o raumatic eve	9	19a. Informant's Na		ype, Print)		19b. Mailir	g Address (Street a	and Numb	er or Rura	l Route Numb	er, City or To	wn, State, Zip	Code)
	and 2 sh Health a tem 27 is	3	Paul W:	ilkinson	(brother)		1	anube Ciı					207	
ore,	of Heal fitem		20a. Method of Dis		Removal from State		lace of Dispo	sition (Name of natory or other plac	e)		Date	20c. Loca	ation - City or	Town, State
ij	ment cant: If			5 Other (Speci		Scar	rpelli	Funera1	Hm.	3/9/	2012		aptown	
Baltimore,	permit. Page 1 a Department of H Important: If ite any injury or otl		21. Signature of F	Sich Y 1	James F.	Scarpe		. Name and Addres						e,PA. 757
			23a. Part 1. Enter		plications that cause one cause on each lir	d the death	n. Do not ente	er the mode of dyin	g, such as	s cardiac c	or respiratory a	arrest,		Approximate Interval Between
	Physician/	8 8	Immediate Cause	Final	THE SECOND STATE OF THE	A	uto.							Onset and Death
	Medical Examiner		resulting in death)		Due to (or as	a consequ	ence of):	2		1	infar isea olem			
	Examino	er	Sequentially list co	enditions,	b. Due to (or as	0%	nary	to acre	ey	- 9	isea	se.		
	ed nsit	Examiner	if any, leading to in cause. Enter Under Cause (Disease or	rlying	Due to (of ac	a consequ	Hir	po cha	1001	6001	olem	ia		
	ate be executed chysician and the burial-transit	Exa	that initiated event resulting in death)	S	C. Due to (or as	a consequ	ience of).	CALINA		W				
09	e be e ysicia ne bur	dical			d									
	tificating ph		IF FEMALE:											
Box 687	ne death certifica r the attending pl ched for use as t	Completed by Physician/M	23b. Was decedent in the past 12			2 Feta	l death 3	Ectopic pregnanc	у			23	Bd. Date of del Month	livery Day Year
Bo	the al	ysic	1 Yes 2 Unknowr		4 ☐ Pregnant 9 ☐ Unknown		death 5 L	Other (specify) _						
Ö.	hat the	y Ph	Part II. Other signi	ficant conditions	contributing to death	but not res	ulting in the u	inderlying cause gi	ven in Par	t I.	23e. Did	tobacco use	e contribute to	the cause of death?
S, F	ires the sign of signs and be	q p	Se	vere	Asserti	45	enos	218			1 🗆	Yes 2	No 3□P	robably 4 Unknown
20	v requ	Sete									24a. Wa	s an opsy	24b. Were au	topsy findings available
Sec.	he lav te has	mo									per 1 \square Yes	formed?	death?	s 2 🗆 No
a F	ian: T rtifica ctor, p	Be C	25. Was case reference examiner?	red to medical				26. Pl	ace of De	eath (Chec	k only one)			
ξ	hysic his ce	2	1 🗆 Yes 2	No			ER/Outpatie		4 L I N				Other (Spec	ify)
Division of Vital Records,	ing P	Certificate:	27. Manner of Dear	5 Pending	28a. Date of in (Month, D	jury <i>ay, Year)</i>	28b, Time of injury	work	y at <br Yes 2		28d. Describe	how injury	occurred	
sior	I or Attendi after death. Director: A I in by the fi	tific	2 Accident 3 Suicide	Investigation 6 Could not be	De 28e Place of Ir	niury - At ho	me, farm, str	M 1 L eet, factory, office	res 2	Z	28f. Location	(Street and	Number or Ru	ral Route Number,
i <u>√</u>	after Direct	Cer	4 Homicide	determined	building, e	tc. (Specify	<i>'</i>)	001, 120101), 11110				own, State)		
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transi	Medical	29a. Certifier	Certifying Phy	vsician: To the best of	of my knowl	ledge, death	occurred at the tim	e, date an	nd place, a	nd due to the	cause(s) and	manner as st	ated. cause(s) and manner stated.
	the H hin 24 the Fu nplete	Mec	only one)	3 Certifying Nu	rse Practitioner: To	the best of r	ny knowledge	, death occurred at	the time, d	date and pl	ace, and due to	the cause(s	and manner a	is stated.
_	with to con		29b. Signature and	title of certifier	1	£ / . ₹	h	29c. Licens		0.6	7		signed (Monti	6-2012
)		Mas	repart	xxxu	12/01	000\7				3			
	16		30. Name and add	ress of person who	completed cause of			TINTY IN	MMA	U WI	CUMP	eri a	ND M	ID 2150Z
	Sta	ite	31. Date filed (Mon		22. Regis				1 111.		~ · I ID	UNCA	1-27	
	Registr		M	AR 2 3 20	12 Ochum	J /	. Ac	New York						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month MAR OG 07:35 AM Physician/ Ruth Achatz Medical 4a, Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore University of Mary land Medical Center 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year)
Jan. 21, 1951 Hours 372-56-2734 Michigan Director 1 ☐ M 2 🛣 F 61 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b County within 72 hours after death with the Maryland Director D.C. Washington, D.C. 1 X Yes 2 No None 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 326 B Maryland Ave., N.E. 20002 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White etc. þ 1X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White "natural", 3 Widowed 4 Divorced Completed Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) 2 should be filed within 72 h h and Mental Hygiene. 7 is marked other than "n Elementary/Secondary (0-12) College (1-4 or 5+) Research Methodologist Education Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ruth Elma Green John James Achatz 9a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 61 Mount Vernon St., Boston, Mass. 02108 John Achatz/Brother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Durial 2 Cremation 3 Removal from State Mar.8,2012 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crem. Alexandria, Va. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility DeVol Funeral Home 2222 Wisconsin Ave., N.W., Wash., DC 20007 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final diff colitis Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): 影 To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician a I for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No Month Pregnant at time of death 9 Unknown signed by the a 1 Yes 2 L 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 🗷 No 3 ☐ Probably 4 ☐ Unknown been sign Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an page 2 s autopsy performed 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 2 🔀 No 1 🗌 Yes ျ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28b. Time of Certificate: 28d. Describe how injury occurred 1X Natural 5 Pending Accident Investigation completely filled in by the 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 [only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier P27462 Mar 06,2012 1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

F. W. WANG M. D. 2.7.5 (August 1) Baltimore, MD 21201 E.W. WANG 25 Green St

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

12-02115 Meribeth Allman

amend #1,per me, g926 4-2-12 sm

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

nenbeth Alimar		State of Maryland 1-For State Registrar	•	tificate of D		wentai ny	_	eg. No. 201	2 09298
Physici Medical Exam		1. Decedent's Name (First, Middle, Last) Meribeth Allmen	th Al	lman			2. Date of Deat Month March 13,		3. Time of Death 1820 hrs
		4a. Facility Name (if not institution, give street and number)		4b. (City, Town, or Lo	ocation of Death	March 13,	4c. County of De	
		21 Alder Road			llicott City	Annapo1		Anne Arund	
Funeral Director		213-80-5393 _{1 M 2 K} F	e (I n yrs. Ia		Under 1 Year Months Days	If Under 24Hrs. Hours Min.		th(MM/DD/YYYY) 9. /1961	Birthplace (State or eign Country) Missouri
any		Usual Residence of Decedent 10a. State 10b. County	10c. City,	Town or Location					10d. Inside City Limits
and show :	ō	Maryland Anne Arundel			Ann	apolis			1 X Yes 2 No
Maryland r 28a-f sho ed at ooce.	Director	10e. Street and Number		10	f. Zip Code		10	Og. Citizen of What C	ountry?
with the Maryland ns 23a or 28a-f sho be notified at ooce.		21 Alder Road 11. Marital Status 12. Was Decedent	Ever in I1	S 13 Was De	ecedent of Hispa	21403 anic Origin? (Spe	acify Vas or No.	USA	erican Indian, Black,
death w	Funeral	1 Never Married 2 Married Armed Forces				Mexican, Puerto I		White, etc	
s after ral", o	ģ	3 Widowed 4 X Divorced If Yes, Give Year or Dates:			2 X No .			Specify: Wh	
2 hour "natu	eted	15. Decedent's Education (Specify only highest grade con Elementary/Secondary (0-12) College (1-4 or		16a. Decedent's U during most of	Isual Occupation of working life, D	n (Give kind of w OO NOT use retire	ork done ed)	16b. Kind of Busines	ss/Industry
5-0036 led within 72 hours Hygiene. other than "natur the Medical Exami	Completed	5+	,	Educ	ator .			Educat	ion
21215-0036 uld be filed within 72 hours after death with the Maryland Mental Hygiene. marked other than "natural", or items 23a or 28a-f she c event, the Medical Examiner must be notified at occe		17. Father's Name (First, Middle, Last) Harold Pilcher			18		(First, Middle, M 1erite	faiden Surname)	
2121; wild be fill Mental H marked	To Be	19a. Informant's Name/Relationship (Type, Print)		19b. Mailing Add	dress (Street a	_		ber, City or Town, St	ate, Zip Code)
Baltimore, MD 2121 permit. Pages I and 2 should be fi Department of Health and Mental Importatot: If item 27 is marked iojury or other fraumatic event,		Marguerite Pilcher - Mothe			_			yers, FL 3	
ore, of Hea If iter		20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from Str	ate C	Place of Disposition rematory or other p	lace)		Date	20c. Location - City	
Baltimore, permit. Pages I ar Department of Hee Important: If ite		4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee	Bal	Ltimore C	remator and Address of			Baltimor	
Ba permi Depa Impe		Myelint klobert				001		aylor Fune . Annapoli	eral Home s, MD 21401
Physician		23a. Part I. Enter the disease, or complications that caused failure. List only one cause on each line.	the death.						Approximate Interval Between Onset and
/Medical Examiner		Immediate Cause (Final disease or condition resulting in death) a. Atherosc1 Due to (or as a conse			vascula:	r Diseas	e		Death
		Sequentially list conditions, b.	squerice or,	<i>j.</i>		_			
	ine	if any, leading to immediate cause. Enter Underlying Cause C.	equence of):					
ed lasit	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a conse	equence of):					
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760, cate be physici he buri	Med	IF FEMALE: 23c. If yes, outcome	ne of pregn	ancy				23d. Date of deliv	ery
lox 6876 eath certificat e attending phy for use as the	cian	23b. Was decedent pregnant in the past 12 months?	time of dea	2 Fetal do	eath 3 (S <i>pecify</i>)	Ectopic pregnan	ncy	Month	Day Year
Box e death c the atten ed for us	Physician/	1 Yes 2 No 9 V Unknown 9 Unknown							
i, P.O.	Ď	Part II. Other significant conditions contributing to death	but not re	sulting in the under	lying cause give	en in Part I.			to the cause of death?
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of Vital Records, g Physician: The law requir ufter this certificate has been s neral director, page 2 should t	gm						autops perform	m <u>ed</u> ? death	
tal Recian: The certificate ector, page	0	25. Was case referred to medical				Death (Check or	nly one)		
F Vit. Physici	10 B	examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatie		ER/Outpatient 3				Residence 6 🗸 Oti	ner: Scene
on of oding Plan.	<u>:</u>	27. Manner of Death 1 X Natural 5 Pending 28a. Date of Inju (Month, Day,Y	ear)	28b. Time of Injury		at vvork?	28d. Describe h	ow injury occurred	
Division In or Atteodi rs after death. al Director: A	ficat	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of In	iury - At hoi	me, farm, street, fa	ctory, office build	ding, etc.			Rural Route Number, City
Div spital or tours afte ceral Div	Certification	4 Homicide determined (Specify)					or Town, St	ate) ————————	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Fuoeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - trans	edical	29a. Certifier (Check only one) Certifying Physician: To the best of my one) Physician: To the best of my one)							
To To com	Med	29b. Signature and title of certifier			29c. License n			29d. Date signed (M	
		Pate 1 - Polle ~			O.C.M.	E.		March 14, 2012	2
0,0	ľ	30. Name and address of person who completed cause of d Patricia Aronica-Pollak MD. Assistant M			\/\ Dal*i	oro Street D	ltimere MC	1 21222	
W	ate		's Signatur	xaminer 900	vv. pailimo	Ba	aumore, ML		
Regist	rar	31. Date filed (Month, Day, Year) MAR 2 1 2012 32. Fegistral	4	back					

DHMH 17 Rev 1/2001 OCME 2006

		1 - For AMEND#19A per FH State of Maryland / Department of Health and Certificate of Death	Mental Hy	giene	10	00299
		- Registrar 3/9/12 AAO HEALTH DEPT. ONH Certificate of Death 1. Decedent's Name (First, Middle, Last)	2. Date of De	Reg. No. 🔼 🔱	14	00200
Physicia Medic		William A. Allsup Sr	March		012	3. Time of Death 0442 M
Examin		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Dea Baltimore Washington Medical Center Glen Burn		4c. County		unde1
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year I f Under 24 Hrs. $216-48-8659$ 1×10^{-1} M $2 \cdot 10^{-1}$ F $61 \cdot 10^{-1}$ Yrs.		v, Year)	Coun	place (State or Foreign try) yland
nd show at	៦	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	1		l	0d, Inside City Limits
Maryla 28a-f s otified	Director	Maryland Anne Arundel Glen Burnie				1 ☐ Yes 2 X No
ith the 23a or st be n		10e. Street and Number 10f. Zip Code 110 Roosevelt Ave 21061		10g. Citizen of US		ntry?
death v items ner mu	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? If Yes specify Cuban Mexican Puer	Specify Yes or No- to Rican, etc.)	14. Rad	ce - Americ	
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permit permit Depart Impor any in		21. Signature of Funeral Service Licensee Winname Recusse of ScilitSO1 1922 Forest Dr.		_		21401
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death certifice attending	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Ver 2 □ Ne 1 □ Ver 2 □ Ver 2 □ Ver 2 □ Ver 2 □ Ver 2 □ Ver 2 □ Ver 2 □ Ver 2 □ Ver 2 □ Ver 2 □ Ver 2 □ Ver 2 □ Ver 2 □ Ver 2 □ Ver 2 □ Ver 2 □ Ver 2 □ Ver 2 □ Ver 2 □ Ver 2 □ Ver 2 □ Ver 2 □ Ver 2 □ Ver 2 □ Ver 2 □ Ver 2 □ Ver 2 □ Ver 2 □ Ver 2 □ Ver 2 □ Ver 2 □ Ver 2 □ Ver 2 □ Ver 2 □ Ver 2 □ Ver 2 □ Ver 2 □ Ver 2 □ Ver 2 □ Ver 2 □ Ver 2 □ Ver 2 □ Ver 2 □ Ver 2 □ Ver 2 □ Ver 2 □ Ver 2 □ Ver 2 □ Ver 2 □ Ver 2 □ Ver 2 □ Ver 2 □ Ver 2 □ Ver 2 □ Ver 2 □ Ver 2 □ Ver 2 □ Ver 2 □ Ver 2 □ Ver 2 □ Ver 2 □ Ver 2 □ Ver 2 □ Ver 2 □ Ver 2 □ Ver 2 □ Ver 2 □ Ver 2 □ Ver 2 □ Ver 2 □ Ver 2 □ Ver 2 □ Ver 2 □ Ver 2 □ Ver 2 □ Ver 2 □ Ver 2 □ Ver 2 □ Ver 2 □ Ver 2 □ Ver 2 □ Ver 2 □ Ver 2 □ Ver 2 □ Ver 2 □ Ver 2 □ Ver 2 □ Ver 2 □ Ver 2 □ Ver 2 □ Ver 2 □ Ver 2 □ Ver 2 □ Ver 2 □ Ver 2 □ Ver 2 □ Ver 2 □ Ver 2 □ Ver 2 □ Ver 2 □ Ver 2 □ Ver 2 □ Ver 2 □ Ver 2 □ Ver 2 □ Ver 2 □ Ver 2 □ Ver 2 □ Ver 2 □ Ver 2 □ Ver 2 □ Ver 2 □ Ver 2 □ Ver 2 □ Ver 2 □ Ver 2 □ Ver 2 □ Ver 2 □ Ver 2 □ Ver 2 □ Ver 2 □ Ver 2 □ Ver 2 □ Ver 2 □ Ver 2 □ Ver 2 □ Ver 2 □ Ver 2 □ Ver 2 □ Ver 2 □ Ver 2 □ Ver 2 □ Ver 2 □ Ver 2 □ Ver 2 □ Ver 2 □ Ver 2 □ Ver 2 □ Ver 2 □ Ver 2 □ Ver 2 □ Ver 2 □ Ver 2 □ Ver 2 □ Ver 2 □ Ver 2 □ Ver 2 □ Ver 2 □ Ver 2 □ Ver 2 □ Ver 2 □ Ver 2 □ Ver 2 □ Ver 2 □ Ver 2 □ Ver 2 □ Ver 2 □ Ver 2 □ Ver 2 □ Ver 2 □ Ver 2 □ Ver 2 □ Ver 2 □ Ver 2 □ Ver 2 □ Ver 2 □ Ver 2 □ Ver 2 □ Ver 2 □ Ver 2 □ Ver 2 □ Ver 2 □ Ver 2 □ Ver 2 □ Ver 2 □ Ver 2 □ Ver 2 □ Ver 2 □ Ver 2 □ Ver 2 □ Ver 2 □ Ver 2 □ Ver 2 □ Ver 2 □ Ver 2 □ Ver 2 □ Ver 2 □ Ver 2 □ Ver 2 □ Ver 2 □ Ver 2 □ Ver 2 □ Ver 2 □ Ver 2 □ Ver 2 □ Ver 2 □ Ver 2 □ Ver 2 □ Ver 2 □ Ver 2 □ Ver 2 □ Ver 2 □ Ver 2 □ Ver 2 □ Ver 2 □ Ver 2 □ Ver 2 □ Ver 2 □ Ver 2			ate of delive	ery Day Year
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1444		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ANDREW GORDEN, MD 2003 Medical Phany SK 100	Amzped.	CM, 2	214	01
Stat Registra	te ar	31. Date filed (Month, Day, Year) 9 2012 32. Registrar's Signature J. Jane				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death MARGH Physician/ HOMAS MOS 2012 3.58A Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Sanctuary at Holy Cross Burtonsville Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign Months 212-76-0098 **Director** 1 🕱 M 2 🗆 F 53 Washington, DC October 24, 1958 Usual Residence of Decedent 28a-f show 10a. State 10b. County notified at 10c. City, Town or Location Director 10d. Inside City Limits Laure1 Maryland Anne Arundel 1 X Yes 2 No 10e. Street and Number ō 10f. Zip Code 10a. Citizen of What Country? event, the Medical Examiner must be Funeral 23a 453 Old Line Avenue 20724 USA within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1. Marital Status Race - American Indian, Armed Forces? Black, White, etc. ŏ þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. "natural", 3 Widowed 4 Divorced Specify: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Elementary/Secondary (0-12) College (1-4 or 5+) Electrical Industry Electrician Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Ransel V. Amos Alvara Ethel Morina 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Howard L. Amos / Brother 3104 Parkway, Cheverly, MD 20785 injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🖾 Burial 2 🗌 Cremation 3 🗀 Removal from State 4 Donation 5 Donation 5 Other (Specify) Fort Lincoln Cemetery 3/15/2012 Brentwood, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility any 4739 Baltimore Avenue Gasch's Funeral Home, P.A. Hyattsville, MD 20781 23a. Part 1. Enter the disease, or complications that caused the death. Donot enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ METASTATIL END CARCINOMA disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner PHKNOWN Ecque Itally list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): or Attending Physician; The law requires that the death certificate be executed Cause (Disease or injury that initiated events and the burial-tran Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as f attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Year Dav been signed by the a should be detached Yes 2 No Unknown g
Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably Unknown 24a. Was an 24b. Were autopsy findings available has funeral director, page 2 autopsy prior to completion of cause of performed hours after death. Ineral Director: After this certificate 2 No ☐ Yes 2 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner_of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury 1 Yes 2 No Accident Investigation Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number 4 🗌 Homicide determined City or Town, State) To the Hospital within 24 hours

To the Funeral Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier

State Registrar (Check

SN

31. Date filed (Month, Day,

e and title of certifier

Name and address of person

P-D

who completed cause of death (Item 23a) (Type, Print)

MD

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

BOX

28595

29d. Date signed (Month. Day, Year)

3

WINGS

MILL

12

12-02235 Davi

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

David Earl Athey			ate of Maryland	l / Departme <i>Certific</i> a	nt of te of	Health and Death	ivientai r	Tygieti	Reg. N	o. 20	12 0	3301
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Funeral	5.	Social Security Number	6. Sex 7. /	Age (In yrs. last birth	iday)	If Under 1 Year Months Days		-	eb 20,		Foreign Country MD	
Director		217-54-7027	1⊠M 2□F	63	Yrs.			_ F	3D ZU,	1949	1110	
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Maryl 28a-	Director	De. Street and Number	hester Road				2150	2	I		USA	
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Shoul shoul and N is m	^၉	Charles Ath	ey	brother	10	1030 COL	1115611110	11 100	<i>1</i> 0 1 0 0	011.0.0	- City or Town, State	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	1	20a. Method of Disposition			of Dispo	sition (Name of c ther place)	emetery,	Date	' l'			
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Division of Vital Records, pital or Attending Physician: The law require unts after death. For a Director: After this certificate has been si filled in by the funeral director, page 2 should by filled in by the funeral director, page 2 should be a page 2 should be a page 2 should be a page 2 should be a page 2 should be a page 2 should be a page 2 should be a page 2 should be a page 2 should be a page 2 should be a page 2 should be a page 2 should be a page 2 should be a page 2 should be a page 2 should be a page 2 should be a page 2 should be a page 3 should be a page 3 should be a page 3 should be a page 3 should be a page 3 should be a page 3 should be a page 3 should be a page 3 should be a page 3 should be a page 3 should be a page 3 should be a page 3 should be a page 3 should be a page 3 should be a page 3 should be a page 3 should be a page 3 should be a page 3 should be a page 3 should be a page 3 should be a page 3 should be a page 3 should be a page 3 should be a page 3 should be a page 3 should be a page 3 should be a page 3 should be a page 3 should be a page 3 should be a page 3 should be a page 3 should be a page 3 should be a page 3 should be a page 3 should be a page 3 should be a page 3 should be a page 3 should be a page 3 should be a page 3 should be a page 3 should be a page 3 should be a page 3 should be a page 3 should be a page 3 should be a page 3 should be a page 3 should be a page 3 should be a page 3 should be a page 3 should be a page 3 should be a page 3 should be a page 3 should be a page 3 should be a page 3 should be a page 3 should be a page 3 should be a page 3 should be a page 3 should be a page 3 should be a page 3 should be a page 3 should be a page 3 should be a page 3 should be a page 3 should be a page 3 should be a page 3 should be a page 3 should be a page 3 should be a page 3 should be a page 3 should be a page 3 should be a page 3 should be a page 3 should be a page 3 should be a page 3 should be a page 3 should be a page 3 should be a page 3 should be a page 3 shou	Certification:	3 Suicide 6 Homicide	Could not be determined (Specify)								
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To the Hos within 24 hu To the Fun	Medical	one) 2 Medica	I Examiner: On the basis and manner	of examination and	or inves	algation, in my op	miori, double of				igned (Month, Day	Year)
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.1 .		30. Name and address of p		use of death (Item 2	3a)	V. Baltimore	Street. Balti	more, M	D 21223			
MV		Zabiullah Ali, M.C		egistrar's Signature	100							
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Ginger Cove Health Center Annapolis Anne Arundel If Under 24 Hrs. ocial Security Numbe 1 Year 9. Birthplace (State or Foreign last birthday If Under 8. Date of Birth **Funeral** 97 (Month, Day, Yea May 15, 1 Months Davs Hours Min 223-60-6972 Director 1 🗆 M 2 🗹 1914 Maryland Yrs 28a-f show 10a. State 10d. Inside City Limits the Maryland items 23a or 28a-f sho her must be notified at 10c. City. Town or Location Director Maryland Anne Arundel Annapolis 1 Yes 2 X No 10g. Citizen of What Country? U.S.A. 10f. Zip Code 10e. Street and Number 21401 Funeral 7110 River Crescent Drive with t death Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, er than "natural", or iter the Medical Examiner Armed Forces? Black White etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: White 3XXWidowed 4 ☐ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b, Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname of Health and Mental H f item 27 is marked ot r other traumatic ever ပ Julian Owen Snow Marguerite Lee Brittingham 19b. Mailing Address (Street and Number or Rural Route Number, City, or Town, State, Zip Code) 20 Somerset Road Rehoboth Beach, Delaware 19971 19a. Informant's Name/Relationship (Type, Print) Henry W. Buse, III/son t of Health a 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 \square Burial 2 \blacksquare Cremation 3 \square Removal from State ō Department Important: If any injury or Baltimore Crematory 3/10/2012 Baltimore, Maryland 4 Donation 5 Other (Specify) . Signal of Fineral Service Alcensee 22. Name and Address of Facility John M. Taylor Funeral Home 0 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): burial-trar that initiated events Due to (or as a consequence of): resulting in death) Last ed by the attending physician detached for use as the buria Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE yes, outcome of pregnancy

Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Pregnant at time of death Other (specify) 1 Yes 212 g 🗌 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by cate has been sig ; page 2 should b 2 No 3 Probably 4 Lunknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an After this certificate has autopsy director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 2 No မ 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 24 hours after death.

Funeral Director: After this etely filled in by the funeral of 27. Manner eath 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hor To the Fune completely f Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year, T

State Registrar

10

31. Date filed (Month, Day, Year)

30. Name and address of person who comp

use of death (Item 23a) (Type, Print) 32/ Registrar's Signature

MAR U 9 2012

FENSE HWY

ANNAPOLIS, M.D. 21401

12-01903 Gene Byrd Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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Medical Exa			Gene Herl	ert By	rd						N.	Month Narch 6, 20	012	Year	1525 hrs
			4a. Facility Name (eet and number)			wn, or Location o			4c. C	ounty of Death	
		Н	Anne Aruno	lel Medical	Center				Annap	olis				ne Arundel	
Funer Direct			5. Social Security N 229 293 -42-6	lumber 550	6. Sex		je (In yrs. I 78	ast birthday) Yrs	If Under Months		Min	. Date of Birth		Foreig	thplace (State or in untry) VA
>		-	Usual Residence o 10a. State				Iana City	Town or Locat	ion						10d. Inside City Limits
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Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-fahr	must be notified at once.	runeral	11. Marital Status 1 Never Marri	-	arried 1		? No	If Y	es, specify	t of Hispanic Orig Cuban, Mexican,				White, etc.	can Indian, Black,
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hour	Exam	<u> </u>	15. Decedent's E			Gnest grade cor College (1-4 or				ccupation (Give king life. DO NOT u		done	IOD, KING	or business/i	ndusti y
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5-00 ed with	Me Me	ᅙ	17. Father's Name	(First, Middle,	Last)					18.Mother's	s Name (Fir	st, Middle, M	aiden Sur	rname)	
21215-0036 and be filed within 7 Mental Hygiene. marked other than	ent, ti	I	Newman H	Byrd						Mary	y Holl	Land			
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ore, slan of Hea If ite	re tr		20a, Method of Dis 1 Burial 2		3	Removal from St		Place of Dispos crematory or ot		e of cemetery,	Da	ate	20c. Loc	ation - City or	Town, State
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Baltimore, MD permit. Pages 1 and 2 sho Department of Health and Important: If Item 27 is	jury	ſ	21. Signature of Fu	neral Service	Licensee	3000		22. 1	Name and A	ddress of Facility	Harde	esty F	unera	al Home	e P.A.
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Box 687 e death certifice the attending p	for use as the	200	1 Yes 2	No 9 Unk	nown 9		ume or de	5 O	ther (Speci	fy)					
the d	detached	타	Part II. Other sign	ficant conditi			h but not r	esulting in the	underlying	cause given in Par	rt I.	23e. Did tob	acco use	contribute to	the cause of death?
P.C ss that		6										1 Yes	2 🗸 N	o 3 Prob	oably 4 Unknown
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COF law 1	u	림	4-									autops	ned?	death?	completion of cause of
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Division of Vital Records, P.O. ral or Atteodiog Physician: The law requires that the state death. al Director: After this certificate has been signed by	era l	<u></u>	1 Yes 27. Manner of Dea	2 No		28a. Date of Inj	ury	28b. Time of		Bc. Injury at Work		I. Describe ho			-
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/iSic r Atte ter des irecto	n by t	<u> </u>	2 Accident 3 Suicide		tigation dinot be	28e. Place of I	njury - At h	ome, farm, stre	et, factory,	office building, etc	c. 28f.			Number or Ru	ral Route Number, City
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Division of Vital Records, P.O. Box 68760, To the Hospital or Atteodiog Physician: The law requires that the death certificate be executed within 24 hours after death. To the Fuoeral Director: After this certificate has been signed by the attending physician and	etely f	<u> </u>	29a. Certifier 1	Certifying Ph	ysician:	To the best of m	y knowled	ge, death occu	rred at the	ime, date and pla opinion, death occ	ce, and due	to the cause	(s) and m	nanner as state	ed
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death March 6, Day 2012 Year Physician/ 8:45 A M George Wilton Bryant Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 01ney Montgomery Montgomery General Hospital Birthplace (State or Foreign Country) Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** Director 217-18-2216 1 XM 2 □ F 90 Sept. 10, 1921 Maryland Usual Residence of Decedent 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits must be notified at Director 1 Yes 2 No Maryland | Montgomery Silver Spring 5 10e. Street and Number 10g. Citizen of What Country? Funeral items 23a 3700 International Drive - Apt 214 20906 U.S.A. filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 \(\overline{\Delta} \) Yes 2 \(\overline{\Delta} \) No If Yes, Give . Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, other traumatic event, the Medical Examiner Black, White, etc. or þ 1 XNever Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify 'natural", 3 Widowed 4 Divorced Specify: White Year or Dates. WWII Completed 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business/Industry
Internal Revenue (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) nd Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Service Revenue Agent 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) .. Page 1 and 2 should be file tment of Health and Mental tant: If item 27 is marked o Wilton Lee Bryant Irene Snyder 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Darrell L. Bryant - Nephew 404 East Dynasty Drive, Cary, North Carolina 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State rtment of l Department of Important: If it any injury or o 1 X Burial 2 Cremation 3 Removal from State Ft. Lincoln Cemetery 3/10/12 Brentwood, Maryland 4 Donation 5 Other (Specify) 21. Signature of Fun ral Service Leensee 22. Name and Address of Facility Molesworth-Williams P.A., Funeral Home Novert 26401 Ridge Road, Damascus, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ 15 disease or condition resulting in death) Medical Examiner Sequentially list nonditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury burial-tran that initiated events Due to (or as a consequence of resulting in death) Last attending physician Physician/Medical requires that the death certificate be Division of Vital Records, P.O. Box 68760 as the t IF FEMALE nse s 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Pregnant at time of death 5 Other (specify) 1 Yes 2 L 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an To the Hospital or Attending Physician: The law mithin 24 hours after death.

To the Funeral Director: After this certificate has be 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify, 10 1 Shipatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred 28c. Injury at 1 Natural 5 Pending iniury work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one)

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Registrar DHMH 17 Rev 06-2011

State

29b. Signat

31. Date filed (Month, Day, Year)

MD

PRINCE

MAR 08

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PH121

DrIVE

29c. License number

D0068026

PADMAJA

OLNEY

29d. Date signed (Month, Day, Year)

06/2012

03

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2012 Year Physician/ MARCH 6, 6:45 P M CATHERINE BUDESHEIM **EDITH** Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington Breathedsville Boonsboro If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours 175-10-5935 **Director** 1 □ M 2 1 F 94 Nov 8, 1917 Maryland Usual Residence of Decedent 28a-f show 10d. Inside City Limits ms 23a or 28a-f shormust be notified at 10a, State 10b. County 10c. City, Town or Location with the Maryland Director Boonsboro Maryland Washington 1 Yes 2X No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 21713 USA 18549 Breathedsville Road items death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian 11. Marital Status Examiner Black, White, etc. ò þ 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates. Maryland 21215-0036 within 72 hours after white 1 Yes 2XXNo Specify. "natural", Completed 3 X Widowed 4 Divorced the Medical 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry and Mental Hygiene. is marked other than College (1-4 or 5+) Elementary/Secondary (0-12) Own home Homemaker event, Be 18. Mother's Name (First, Middle, Maiden Surname) Page 1 and 2 should be filed 17. Father's Name (First, Middle, Last) 2 Lillian Waltz George William Kimmell traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 19a. Informant's Name/Relationship (Type, Print) Kimberly Kaiktsian - granddaughter 18549 Breathedsville Road, Boonsboro, Maryland it of Health : other t Baltimore, 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Department of Important: If any injury or injury or 3-12-2012 4 ☐ Donation 5 ☐ Other (Specify) Mt. Olivet Cemetery Frederick, Maryland ture of Funeral Service Licensee 22. Name and Address of Facility Stauffer Funeral Home 1621 Opossumtown Pike, Frederick, Maryland 21702 eanul 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ DEMENTIA ALZHERMERS disease or condition y-ears) Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of): burial-transi Cause (Disease or injury that initiated events resulting in death) Last and Due to (or as a consequence of) attending physician Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 use as the IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No for Month 5 Other (specify) Day Pregnant at time of death been signed by the a should be detached Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an page 2 s autopsy performed? Yes 2 this certificate 1 Yes 2 No 25. Was case referred to medical filled in by the funeral director, 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 1 Yes ER/Outpatient 3 DOA 1 Inpatient 2 I 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 24 hours after death. Funeral Director: After iniury 1 🔀 Natural 5 Pending Investigation Accident Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 32171

Registrar
DHMH 17 Rev 06-2011

7

State

20

32. Registrar's Signature

MAKAN

328

WALKERSVILLE

21793

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GUUGH

Ricuso

31. Date filed (Month Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ ^D2012 March 6, 19:03 Shirley Ann Butler Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Washington Adventist Hospital Takoma Park Montgomery If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Hours Min (Month, Day, Year) **Director** 578-48-9475 1 M 2 🖺 F July 30, 1936 75 28a-f shov 10b. County iral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 72 hours after death with the Maryland Director Clinton 1 A Yes 2 No Maryland Prince George's 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9503 Tellico Place 20735 United States 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married "natural", or þ Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Black Completed 3 Widowed 4 Divorced Specify: Year or Dates. permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry uld be filed within 72 ind Mental Hygiene, (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Nurse Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Clarence H. Butler I Alberta Holland 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cary M. Butler - Son 9503 Tellico Place Clinton, Maryland 20735 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Marchate 13, 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Marvland National 2012 Laurel, Maryland 21. Signature of Funeral Service Ligensee 22. Name and Address of Facility Stewart Funeral Home, Inc. John stewa M00560 4001 Benning Road NE Washington, DC 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Exami The law requires that the death certificate be executed 0 sician and burial-tran Due to (or as a consequence of) attending physician I for use as the buria Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day Pregnant at time of death 5 Other (specify) signed by the at d be detached for Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed plnous peen 24b. Were autopsy findings available prior to completion of cause of has autopsy performed? death? nin 24 hours after death. the Funeral Director: After this certificate I apletely filled in by the funeral director, pag 1 ☐ Yes 2 ☐ No Yes 2 10 To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 1 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: 28c. Injury at 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined

Registrar

within 2 To the

Medical

29a. Certifier

(Check

only one)

29b. Signature and title of certifier

31

31. Date filed (Month, Day, Year)

MO

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BLUD 32. Degistrar' Signature

DHMH 17 Rev 06-2011

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

DOO 60 60

f your in

29c. License number

City or Town, State)

10

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 12-02097 State of Maryland / Department of Health and Mental Hygiene Gloria Elizabeth Byrd 1- For State Certificate of Death Reg. No. Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ March 13, 2012 0543 hrs **Medical Examiner** Gloria Elizabeth Byrd 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death Prince George's **Doctors Hospital** Lanham If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) **Funeral** oreign Court Jash., D.C. Days Hours Months 09/01/1949 Director 213-56-5315 62 Yrs 1 M 2 👽 F Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City. Town or Location 10b. County Md. P.G. Seat Pleasant 1 X Yes 2 No or items 23a or 28a-f show Baltimore, MD 21215-0036
permit. Pages I and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked wher than "natural", or items 23s or 28s-f shu
isjury or other traumatic event, the Medical Examiner must be notified at once. Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 608 64th Place 20743 Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No 14. Race - American Indian, Black, 11 Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 Never Married 2 Married 1 Yes 2x X No Black 1 Yes 2X No specify: Specify 3 Widowed 4 Divorced If Yes. Give Year 2 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Stock Broking Bookkeeping Supervisor 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Elizabeth Payne å Eddie Simpkins 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 608 64th Place, Seat Pleasant, Maryland 20743 Antoinette M. Byrd/Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a Method of Disposition crematory or other place) 1 K Burial 2 Cremation 3 Removal from State Landover, Maryland 03/24/12 Harmony Mem. Park 4 Donation 5 Other Specify. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Henry S. Washington & Sons Co., Inc. St.C 10414 CC0316 4925 Burroughs Ave., N.E., Washington, D.C. 20019 Approximate Interval 23a. Part I. Ent. the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Between Onset and /Medical Death Immediate Cause (Final disease a Methadone Intoxication xaminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions Due to (or as a consequence of) if any, leading to immediate Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) and Physician/Medical AMENDED 23a, 27, 28a-f, per me, g932 10-17-12 sm attending physician for use as the burial -X UNPENDED IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 3 Ectopic pregnancy Live birth Fetal death Month Day Year 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 ✔ No 9 Unknown Unknown has been signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 V Unknown Completed 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of performed death? 2 No page ✓ Yes 2 No 1 🗸 Yes certificate 26.Place of Death (Check only one) 25. Was case referred to medical examiner? Other Nursing Home 5 Residence 6 Other: this 1 🗸 Yes 2 No 28c. Injury at Work 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury After 27. Manner of Death Certification Naturai 1 Yes 2 X No unknown 5 Pending fd 3-13-12 fd 05:06 am

Huspital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

hours after death.

uneral Directur: A
ly filled in by the fu within 24 hours at To the Funeral I

28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 6 X Could not be Suicide determined (Specify) Homicide Nursing Home unknown Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated

Investigation

30. Name and address of person who completed cause of death (Item 23a) Pamela E. Southall, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

State 31. Date filed (Month, Day, Year, Registra

29b. Signature and title of certifie

2 Accident

Medical

ORIGINAL

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

March 14, 2012

or Town, State)

State of Maryland / Department of Health and Mental Hygiene For State State Registrar AMEND#11, 17+18perFH, 3/15/12; BMW, McODertificate of Death 3. Time of Death . Decedent's Name (First, Middle, Last, 2. Date of Death Month March Physician/ 2012 2:07 P M Barbara Pendleton Carlin Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Casey House Rockville If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Director 577-46-1109 1 🗆 M 2 🕱 F 78 Yrs Sept 24, 1933 Warrenton, VA 28a-f shov 10a. State 10b. County 10c. City. Town or Location the Maryland notified at Director Bethesda 1 Yes 2 X No Maryland Montgomery 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? ō ms 23a or must be r Funeral 20814 United States 9927 Dickens Avenue items death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Was Deces. Armed Forces? 14. Race - American Indian, 11. Marital Status Examiner Black, White, etc 5 þ 1 Never Married 2 William Baltimore, Maryland 21215-0036 within 72 hours after Caucasian If Yes, Give Year or Dates 1 Yes 2X No Specify. "natural", 3 Widowed 4 Divorced Completed Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working (Specify only highest grade completed) al Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) the Public School 12 Administrative Assistant Be 18. Mother's Name (First, Middle, Maiden Surname) Certrude Porter 17. Father's Name (First, Middle, Last) Horace Rowe and Mental 2 Gertrude unknown unknown Rowe traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a Ron Pendleton, Son 9927 Dickens Avenue, Bethesda, Maryland 20814 other 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cernetery, crematory or other place) Department of Important: If it any injury or o once. 1 ☐ Burial 2 **X** Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Ft. Lincoln Crematory 3/13/2012 Brentwood, Maryland 22. Name and Address of Facility Simple Tribute 21. Signature uneral Service Licensee MO1102 6 1040 Rockville Pike, Rockville, Maryland 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Mesothelioma of the peritoneum disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate Cause (Disease or injury that initiated events and Due to (or as a consequence of) resulting in death) Last physician the bur Medical certificate be Division of Vital Records, P.O. Box 68760 as attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death Physician/ 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? To the Hospital or Attending Physician: The law requires that the death jo Month Day Year Pregnant at time of death ed by the a detached f 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 N page 2 After this certificate 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 2 1 Yes 2 X No 4 Nursing Home 5 Residence 6 Nother (Specify) Hospice 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 Yes 2 No 28b. Time of 28d. Describe how injury occurred Certificate: 5 Pending X Natural Accident
Suicid Investigation after death filled in by the Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined within 24 hours a Medical 1 🛣 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗌 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month. Day. Year) D37142 March 4, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Geoffrey Coleman, 1355 Piccard Drive Suite 100, Rockville, Maryland 20850 31. Date filed (Month, Day, Year, State MAR 12 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Cikk Robert 2012 10:00 PM March 0წ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Crofton Convalescent & Rehab Center Crofton Anne Arundel Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Months Davs Hours Min 92 **Director** 577-56-5860 1 XM 2 🗆 F Aug. 19,1919 Czechoslovakia Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10d. Inside City Limits 10c. City. Town or Location Director MD Anne Arundel Crofton 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 1 and 2 should be filed within 72 hours after death with the if Health and Mental Hygiene. I the Azi is marked other than "natural", or items 23a or other traumatic event, the Medical Examiner must be a other traumatic event, the Medical Examiner must be a Funeral 2131 Davidsonville Road 21114 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces?

1 Yes 2 X No Black, White, etc. 1 Never Married 2 Married b Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: White Completed 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Tailor Tailoring 8 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Israel Cikk Farkas Malka 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sandy Schachter / Daughter 136 Wye Oak Court Severna Park, MD 21146 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State March 08 Department of I Important: If it any injury or o 1 X Burial 2 Cremation 3 Removal from State Mount Lebanon Cemetery Adelphi, MD 2012 4 ☐ Donation 5 ☐ Other (Specify) Barranco & Sons, P.A. Severna Park Funeral Home 495 Ritchie Hwy, Severna Park, MD 21146 21. Signature of Fuperal Service Licensee sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, are. List only one cause on each line. 23a. Part 1. Enter shock, or heart Immediate Cause (Final disease or condition Onset and Death Ph_sician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, ir any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): nding physician and use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical The law requires that the death certificate be P.O. Box 68760 IF FFMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) Day Pregnant at time of death , the a signed by the Part II. Other significant conditions contributing to death, but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably Vinknown Completed should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed has Il or Attending Physician: The safter death. Director: After this certificate 1 Yes V No Yes 2 10 25. Was case referred to medical filled in by the funeral director, Be 26. Place of Death (Check only one) ie No 1 Yes 2 1 Inpatient 2 ER/Outpatient 3 DOA 41 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manne of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 \square Pending Natural work? 1 ☐ Yes 2 ☐ No Investigation Accident 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined

State

24 hours

To the I within 2 To the F

Medical

29a. Certifier

only one 29b. Signature and Med

title of

30. Name and address of person who completed

Registrar

DHMH 17 Rev 06-2011

Ce tifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

ying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

al Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month. Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death Reg. No. Registrar I. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 7:27 P M. MARCH Aaron Conway 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Glen Burnie Baltinge Washington Medical CENTER
5. Social Security Number 6. Sex 7. Age (In yrs. last birthda Anne Arundel 8. Date of Birth 9. Birthplace (State or Foreign If Under 24 Hrs. **Funeral** Hours Year 213-28-3479 **Director** 1**X** M 2 □ F 83 Yrs. July 18 1928 Maryland Usual Residence of Decedent or 28a-f shov notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County rector Maryland Anne Arundel Odenton 1 Yes 2 X No ō 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? rms 23a or Funeral USA 1372 Galloway Rd. 21113 ural", or items 2 death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 XYes 2 No
If Yes, Give
Year or Dates 1951-53 ed Forces Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. **Black** and Mental Hygiene. is marked other than "natural", 3X Widowed 4 Divorced Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) 10th 0 Plumber Ft. George Meade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked of any injury or other traumatic eve 2 John Conway Grace Galloway 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 673 Old Waugh Chapel Rd. Odenton, Md. Sheila V. Isler(Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place 4 ☐ Donation 5 ☐ Other (Specify) Rest 3-10-12 Hanover, Md. Miname aReesen ScilitSons Mortuary, P.A. 21. Signature of Funeral Service Licenses Lavy 21401 1922 Forest Dr. Annapolis, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on, ach line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) to (or as a consequence of) Examiner Sequentially list conditions, Examine Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last the burial-tran and Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 for use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Year 5 Other (specify) Month Dav Pregnant at time of death signed by the Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ should be 1 Yes 2 No 3 Probably 4 Unknown Completed peen : 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No this certificate has page 2 1 ☐ Yes 2 M No filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Hospital 1 Yes မ 1 Ninpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After 1 Natural injury 5 Pending Investigation ☐ Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigating in much in the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the ca Medical 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signa and title of ger 29c. License number

State Registrar Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type,

092012

3

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Mar 9, 2012 Physician/ 11:40 A M Compher Geraldine Grube Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's Riverdale 4813 Madison Street If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 8. Date of Birth 7. Age (In vrs. last birthday) **Funeral** 1 □ M 2 🖾 F Days Hours Min. Los Angeles, CA 579-36-1341 82 Director Usual Residence of Decedent 28a-f show 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location Director Examiner must be notified 1 X Yes 2 No Prince George's Maryland Riverdale 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 20737 USA 4813 Madison Street Hygiene. other than "natural", or items death 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 X Married 1 Yes If Yes, Give 2 X No 72 hours after Maryland 21215-0036 1 ☐ Yes 2 K No Specify: Specify: White 3 - Widowed 4 - Divorced Completed Year or Dates traumatic event, the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) **PEPCO** Clerk and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Arthur Grube Margaret Angus 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st.
Department of Health ar
Important: If item 27 is Maurice T. Compher / Husband 4813 Madison Street, Riverdale, MD 20737 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 3/10/2012 Alexandria, Virginia Metropolitan Crematory 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Ligenses 22. Name and Address of Facility 4739 Baltimore Ave. Gasch's Funeral Home, P.A. Hyattsville, MD 20781 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Phyllician/ Chronic Renal Failure disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Hypertension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) Exami Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): resulting in death) Last attending physician a Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No Month Day Year Unknown 9 Unknown ģ signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas autopsy page performed' After this certificate 1 Yes 2 No Yes 2 N Was case referred to medical 26. Place of Death (Check only one) funeral director. Be Hospital 2 X No ပ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No death. 2 Accident
3 Suicide
4 Homicide Investigation Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined after 24 hours Medical 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifie (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

2

Registrar

31. Date filed (Month, Day,

Michael J. Berard, M.D., 7305 Baltimore Blvd #107, College Park, MD 20740 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

D26287

3/9/2012

State of Maryland / Department of Health and Mental Hygiene

1 - State Amend#23a, 28e, 28, f Per floating and Mental Hygiene
Reg. No. Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Ralph Edward Cook 03 Day 201 2al 603th Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Prince George 5611 Sachem Drive Forest Heights Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 7. Age (In yrs. last birthday) Months Days 152-32-4020 1**X**□ M 2 □ F Hours 68 **Director** Yrs. 09/07/1943 Usual Residence of Decedent 28a-f show at 10a. State 10b. County 10c. City, Town or Location Director items 23a or 28a-f s her must be notified MD Prince George Forest Heights 10e. Street and Numbe 10f. Zip Code 20745 10g. Citizen of What Country? 5611 Sachem Drive 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian an "natural", or iter Medical Examiner Armed Forces?

1 Armed Forces?

1 Yes 2 No
If Yes, Give 1965Year or Dates: 970 þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. SpecifyBlack Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) marked other than matic event, the Me 12th grade College (1-4 or 5+) Electronic Technician Metro other traumatic event, Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic even once. 17. Father's Name (First, Middle, Last) 18. Mother's Name *(First, Middle, Maiden Surname)* Augustine Alexander Ralph Cole 19a. Informant's Name/Relationship (Type, Print)
Sheldon Cook/ son 19b. Mailling Address (Street and Number or Rural Route Number, City or Town, State, Zio Code) 5611 Sachem Dr, Forest Heights, MD 20725 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Cheltenham 03/12/2012 Cheltenham, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee M01388 5635 Eads St, NE 22 Name and Address of Facility urray Funeral Home Washington DC 20019 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ MI Myocardial Infarction disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of). attending physiciar Physician/Medical death certificate be 68760 as 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death asn 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 9 Unknown To the Hospital or Attending Physician: The law requires that the within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the P.0. ģ Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Completed autopsy performed? Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Certificate: To Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🔀 Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 1 Yes 2 No ☐ Accident ☐ Suicide Investigation completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 5611 Sachem Dr. 4 Homicide determined Forest Heights, MD 20745

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check 3 Sertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of 29d. Date signed (Month, Day, Year) ²⁹C 10059658 03/07/2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) John Lee MD 6104 Old Branch Ave, Temple Hills, MD 20748 31. Date filed (Month, Day, Year) 32. Registrar's Signature **State** Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

 3 . Time of Death $^45 pm$

9. Birthplace (State or Foreign

Approximate

Interval Between

Onset and Death

10d. Inside City Limits

1X Yes 2 □ No

New Jersey

Black, White, etc.

Month

Day

24b. Were autopsy findings available prior to completion of cause of death?

Year

DHMH 17 Rev 7/2009

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ March 9, ^D2012 Gerardina Maria Del Pino 6:10 Medical 4a, Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Holy Cross Hospital Silver Spring Montgomery 9. Birthplace (State or Foreign Country) Colombia Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Dec. 23, **Funeral** 7. Age (In vrs. last birthday) 1 M 2 7 Director 578-80-4891 67 Dec. Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits Director Montgomery 1 Yes 2 X No Takoma Park 10e. Street and Number 10g. Citizen of What Country? Funeral 8608 Flower Avenue, Apt. C7 20912 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, "natural", or 1 Never Married 2 Married þ Yes 2 X No Yes, Give Baltimore, Maryland 21215-0036 1₺ Yes 2 No Specify: Colombian Specify.White Completed 3 Widowed 4 Divorced Year or Dates f Health and Mental Hygiene. item 27 is marked other than "natul other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Mail Clerk Insurance Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Carlos Arturo García Maria Salazar off. Page 1 and 2 shours of Health and Mr. m 27 is mr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Adalberto Del Pino/Husband 8608 Flower Avenue, #C7, Takoma Park,MD 20912 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 5 1 X Burial 2 Cremation 3 Removal from State Department of Important: If any injury or March 15 Gate of Heaven Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Silver Spring, MD Signature of Funeral Service Licensee Francis J. Collins Funeral Home Inc. 500 University Blvd. .W, Silver Spring,MD 20901 23a. Part 1. Enter the or ease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death

Chiknywn Immediate Cause (Final athero schwitic Physician/ Cardiovascular disease disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of). burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): nding physician a use as the burial-Physician/Medical that the death certificate be P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery atten 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Pregnant at time of death Month Day Year the g Unknown signed by the detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Diahetes Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed Hypertension 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed Yes 2 within 24 hours after death.

To the Funeral Director: After this certificate I Completed filled in by the funeral director, pag. 1 🗌 Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to predical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Yes ၉ 1 🗌 Inpatient 2 🗷 ER/Outpatient 3 DOA 27. Mann of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, dea ath occurred at the time, date and place, and due to the cause(s) and manner as stated D43121 30. Name and address of person who complete cause of death (Item 23a) (Type, Print) MD; 605 Main St, Laurel, MD20707 HURY

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ March Dag 7 2092 12:30 P Frances Hilda Deeter Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Anne Arunde1 Edgewater South River Health & Rehab. Center 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral Days Hours 1 M 2 7 F Magwhand 0*7//0*/2*9*% 9924 87 Director 219-16-0043 Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 XNo Maryland Anne Arundel Edgewater 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 21037 3411 Hazelwood Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14 Race - American Indian. Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married <u>ک</u> 1 ☐ Yes 2 ☐ No Specify: If Yes Give White 3 X Widowed 4 □ Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry should be filed within 72 and Mental Hygiene.
7 is marked other than "r Elementary/Seconday (0-12) State of Maryland Accounting Machine Operator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည William Franklin Thomas Elizabeth Virginia Tayman permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3411 Hazelwood Road, Edgewater, Maryland 21037 Frances Lee Clow/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date XBurial 2 ☐ Cremation 3 ☐ Removal from State St. Mary's Cemetery 03/09/2012 Annapolis, Maryland 4 ☐ Donation 5 ☐ Other (Specify) of Funeral Service License 22. Name and Address of Facility George P. Kalas Funeral Home alas 2973 Solomons Island Road, Edgewater, MD 21037 23a. Part 1. Enter the disease, or complication, that caused the death. Do not shock, or heart failure. List only one calls, on each line. enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical that the death certificate be 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Day Pregnant at time of death Year ned by the a detached f 9 Unknown 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed 2 🗆 No certificate 1 🗌 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 **N**0 Other: ၉ To the Hospital or Attending Physical within 24 hours after death.

To the Funeral Director: After this a completed filled in by the funeral dil 1 Inpatient 2 ER/Outpatient 3 DOA 4 X Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of injury (Month, Day, Year) 27. Mann of Death 28c. Injury at work? 1 🗌 Yes Certificate: 28b. Time of 28d. Describe how injury occurred Natural Pending 2 Accident 3 Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 🗲 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Maryland 21215-0036

Baltimore,

Box 68760

P.0.

Records,

Division of Vital

31. Date filed (Month, Day, Year) State MAR 09 2012 Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Mitul Dave, 9055 Chevrolet Drive, Ellicott City, Maryland 21042

29c. License numbe

D57313

29d. Date signed (Month, Day, Year) 03/08/2012

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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Examin		4a. Facility Name (if		give street and nun	,	oni t	a 1	4b. City, Town,	or Location			4c. Ce	ounty of Dea	th lerick	
Funeral		Social Security No	umber	6. Sex		In yrs. last		If Under 1 Year Months Days	If Unde	r 24 Hrs. Min.	8. Date of Birl (Month, Da		9. Bir	thplace (State	or Foreign
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laryland 3a-f sho ified at	ector	10a. State Maryland	10b. County Frede	rick		10c. City, 1	Town or Lo		ederio	-k				10d. Inside C	oity Limits es 2 □ No
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1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by	1 ☐ Never Marri		ied Armed For 1 Yes If Yes, Giv Year or Da	2 Ne	。1952 1956	2-	f Yes, specify Cul			rican, etc.)	Sp	Black, Whit	White	
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should and Me is marl		19a. Informant's Na	me/Relationsh		/11		19b. Mailir	ng Address (Stree	t and Numb	er or Rura					
l and 2 f Health item 27 other tr		Michael I		ey, Son		20h Plac	ce of Disno	Circle 1	- 1		Data	20c Loca	tion - City o	Town State	
permit. Page 1 Department of Important: If i any injury or once.		1 Burial 2 Donation		3 ☐ Removal from pecify)	State	cem	Metry cren Metr Crema	natory or other pla copolitan torium,	Inc.	03/0	6/2012	Alexa	ndria	, Virgi	nia.
permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other trai		21. Signature of Fur	neral Service	Jensey Tillaw TV	m	0139	22 M	loleswor 26401 Ric	ess of Eacil	l ^{ty} liam	s, P.A.	, Fun	eral l	Home	
H		shock, or hear	rt failure. List o	complications that only one cause on ea	caused thach line.	he death. I	Do not ente	er the mode of dy	ing, such as	s cardiac o	or respiratory an	rest,	DMY	Approxima Interval Be	ate etween
Physician/ Medical		Immediate Cause (disease or condition resulting in death)		a. Due to		onsequer		H EMO	LL H	4 (E	1	Y 2	OME	Onset and	Death
Examiner	er	Sequentially list co	nditions,	b. — Due to	(or on a c	consequer	200 01:		त ा	04 5	John	IND			
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To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicial completely filled in by the funeral director, page 2 should be detached for use as the bur	Physician/Medic	23b. Was decedent in the past 12 r 1 ☐ Yes 2 ☐ 9 ☐ Unknown	months? ☐ No		Birth 2 nant at t		leath 3	Ectopic pregna Other (specify)	ncy			23	d. Date of de Month	livery Day	Year
requires that the des been signed by the s should be detached	by	Part II. Other signif	icant conditio	ns contributing to d	eath but	not result	ing in the u	nderlying cause (given in Par	t I.				o the cause of Probably 4	
s ician: The law re certificate has be lirector, page 2 sho	Completed										24a. Was autor perfo 1 Yes			topsy findings completion of s 2 No	
ysician: is certific director,	To Be	25. Was case referre examiner? 1 Yes 2	ed to medical	Hospital:	Innatien	at 2 \square FF	3/Outpatier		Place of De		k only one) ome 5 Resid	dence 6	Other (Spor	sife)	
ing Phys I. After this funeral di		27. Manner of Death	h 5 🗆 Pendin	28a. Date		28	Bb. Time of injury	28c. Inju	rk?		28d. Describe h			1 1	,
To the Hospital or Attending Phywithin 24 hours after death. To the Funeral Director: After this completely filled in by the funeral	Certificate:	2 X Accident 3 Suicide 4 Homicide	Investig 6 Could i determ	not be 28e. Place	ng, etc. ((Specify)		eet, factory, office	Yes 2	No			who		W.St.
Hospita 4 hours uneral ely fillec	Medical	29a. Certifier 1 (Check 2	Certifying Medical E	Physician: To the base	est of m	y knowled	lge, death o	occurred at the tir	ne, date and	d place, a	nd due to the ca	ause(s) and	manner as s	tated. cause(s) and m	anner stated.
To the h within 2 To the F	Me	of Fine 3		Nurse Practitioner					t the time, d			he cause(s)		as stated.	
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5		30 Name and a dree CLAVE C 31. Date filed (Month	SS of person v	who completed cause	e of dea	th (Item 23	3a) (Type, P UVG ,	Print) SOLTE	41.	35	Proid	NCE	Mp 2	1702	
Stat Registra	e ir	31. Date filed (Monti	h, Day, Year)	2012 32.5	egistrar's	s Signatur	1. 4	are							_

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ March 7, Day 012 Ann Martin Dimmick 10:25P M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 24411 Kakae Drive Damascus Montgomery 5. Social Security Numbe If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Dec. 27, Year 924 Washington, DC 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 1 □ M 2 🗓 F Months Days Hours 579-28-4531 Director 87 Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland 1 Yes 2 X No Montgomery Damascus 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 24411 Kakae Drive 20872 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Force Black, White, etc. within 72 hours after þ 1 Never Married 2 Married Yes 2 X No Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. 3 X Widowed 4 Divorced Specify: White Completed Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) 12 College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ John Mewshaw Margaret Stakem permit. Page 1 and 2 should be Department of Health and Mem Important: If item 27 is marke any injury or other traumatic once. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret Young - Daughter 4704 Hardwood Court, Mount Airy, Maryland 21771 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Xaurial 2 Cremation 3 Removal from State cemetery, crematory or other place All Souls Cemetery 3/12/12 Germantown, Maryland 4 Donation 5 Other (Specify) 21. Signature of Fur eral Service LTCs 22. Name and Address of Facility
Molesworth-Williams P.A., Funeral Home OV 26401 Ridge Road, Damascus, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death -₽hysician/ disease or condition resulting in death) Congestive Heart Failure Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 XNo Pregnant at time of death Month 1 L Yes 2 L 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 🛣 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No autopsy performed? Yes 2 X No 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? Hospital 2 **X**No ျှ 1 Tes Other: 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home X Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No ☐ Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 🗶 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

0

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Geoffrey Coleman, M.D.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

1355 Piccard Drive,

D37142

Rockville, Maryland

29d, Date signed (Month, Dav. Year)

March 8, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 12:05 P_M Physician/ Month 03 Day()3 Year 2 Medical Emory Davis 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Southern Maryland Hospital Clinton Prince Georges If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth Days Hours Min (Month, Day, Year) **Director** 578-20-9704 1 X M 2 □ F 87 Yrs. 04/14/1924 Bishopville, SC Usual Residence of Deceder show 10a. State items 23a or 28a-f sho her must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director ¥ Yes 2 ☐ No MD Prince Georges Fort Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12021 20744 Livingston Road within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, er than "natural", or iter the Medical Examiner rmed Forces?
Yes 2 No Black, White, etc. 1 Never Married 2 Married ģ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. If Yes, Give Year or Dates Specify: Black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Machinist . Federal Gov. and Mental Hygie is marked other permit. Page 1 and 2 should be filed w Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 EMORY DAVIS ANNIE JANIE BRISBY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Audrey Davis / Wife 715 Gold Valley RD Locust Grove, VA 22508 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Bemoval from State 4 ☐ Donation 5 ☐ Other (Specify) Riverdale Park Crem. Riverdale, MD 03/12/2012 f Funeral Service License 22. Name and Address of Facility Tyrone J Young Funeral Services 5635 Eads Street NE Washington DC, Part 1. Letter the disease, or complications the shock or heart failure. List only one cause of t enter the mode of dying, such as cardiac or respiratory arrest, Approximate Immediate Cause (Final Ph_sician/ disease or condition Medical resulting in death) Due to (as a con Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine that initiated events resulting in death) Last burial-tran and attending physician for use as the buria Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day Year ed by the a been signed to should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an this certificate has ral director, page 2 autopsy performed Yes 2 death? 1 ☐ Yes 2 ☐ No **Division of Vital** 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ၉ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Ma er of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completely filled in by the funer 5 Pending Natural 1 🗌 Yes 2 🗌 No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) Sertifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) March 5. 2012

DHMH 17 Rev 06-2011

Registrar

Date filed (Menth, Day,

Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2012 **GOLDA** 0 DELAUTER March 2:50 A^{M} Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Frederick <u>Frederick Memorial Hospital</u> Frederick If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Country) VA. **Funeral** (Month, Day, 1 🗆 M 2 💢 F Days Months Hours 215-14-5024 Director 90 Dec. Usual Residence of Decedent or 28a-f show 10a. State 10b, Count be notified at 10c. City. Town or Location 10d. Inside City Limits Director Maryland Frederick 1 Yes 2 No Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23a th and Mental Hygiene. 27 is marked other than "natural", or items 23s traumatic event, the Medical Examiner must t 5955 Quinn Orchard Road 21701 U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married ş Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ♣ No Specify: Completed 3 Widowed 4 Divorced Specify: Year or Dates White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Telephone Operator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ira Ross Bageant Nellie Virginia Oates 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a item 27 Patty O'Toole / Daughter 9790 Chestnut Oak Ct., Frederick, Maryland 21701 injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 s
Department of F
Important: If ite
any injury or ot 1 ■ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Grossnickle Cemetery 3/ 8/ 2012 Myersville, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Robert E. Dailey & Son F.H., P.A. 1201 North Market Street, Frederick, MD. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause op each line. Immediate Cause (Final Oaset and Death Physician/ HEART ORONAR disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of): Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical that the death certificate be IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No for Month Day 4 Pregnant 9 Unknown Pregnant at time of death Year g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by law requires ATRIAL FIBRILLATION, DIABETES MELLITUS 1 Yes 2 No 3 Probably 4 Unknown completed filled in by the funeral director, page 2 should HYPERTENSION 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an PULMONARY ANEMIA The Hospital or Attending Physician: of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending Division work? 2 No ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check within 2 To the I only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD DZ1936 one Ison 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ANDREW DINECSON, MO 65C THOMAS WHISON DR. FRENCK MS 2 1702

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

ack

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 29^{Day} Physician/ Month 20°1°2 Dorothea Lorraine Freeman 6:30 PΜ Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Village at Rockville Rockville Montgomery Social Security Number 8. Date of Birth (Month, Day, Year) 11-18-1924 6. Sex 7. Age (In yrs. last birthday If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Min 1 M 2 X F Months Days West Virginia Director 235-36-3314 87 Usual Residence of Decedent show 10a. State with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits Director notified 28a-f MD Montgomery Gaithersburg 1 X Yes 2 No 10e. Street and Number ms 23a or must be r ò 10f. Zip Code 10g. Citizen of What Country? Funeral 221 Booth Street #116 20878 United States be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 XNo 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, the Medical Examiner Black, White, etc. ò þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: WHITE "naturaf" Completed 3X Widowed 4 □ Divorced Specify. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Sales Clerk Retail traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ permit. Page 1 and 2 should be Department of Health and Ment. Important: If item 27 is marked any injury or other Leo Forest Michael Lutie Arnett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda Dianna DeLuca - Daughter 16 Citrus Ct., North Potomac, Maryland 20878 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 \square Burial 2 f X Cremation 3 \square Removal from State 4 ☐ Donation 5 ☐ Other (Specify) National Crematory 3-2-2012 Falls Church, Virginia 21. Signature of Funeral Servi 22. Name and Address of Facility Edward Sagel Funeral Direction 1091 Rockville Pike, Rockville Maryland, 20852 60100 23a. Part 1. Enter the disease, or complications that gaused the death. Do not enter the mode of dving, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of). The law requires that the death certificate be executed Cause (Disease or linjury that initiated events Due to (or as a consequence of) resulting in death) Last the buri Physician/Medical attending physici Box 68760 IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ ρ in the past 12 months? Day Year Pregnant at time of death Yes 2 No detached Unknown 9 Unknown P.O. signed by t d be detach Part II. Other significant conditions countributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>&</u> Division of Vital Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy eral Director: After this certificate filled in by the funeral director, pag 1 Yes 2 No Yes 2 M Hospital or Attending Physician: 25. Was case referred to medica 26. Place of Death (Check only one) Be 2 No 1 🗌 Yes Other: Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury hin 24 hours after death. the Funeral Director: At 1 🗌 Yes 2 🗆 No Accident Investigation Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check npleted 3 [Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 70 29b. Sjgnature and title of certifier Date signed (Month, Day, Year) 201 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 26033 Ridge Road; Damascus, MD 20872 Charles Karesh, M.D. 31. Date filed (Month, Dav. Year 2. Registrar's Signature State MAR 12 Registrar

			State of Maryland / Dep	eartment of Health and artificate of Death		2013	2 09320
			RegistraMEND#24a/bperMD,3/19/12; BMW,McCo Ce	runcate of Death	2. Date of Death	eg. No. <u>LUI</u>	3. Time of Death
	Physicia Medi		Michael Fox-Rabinovich		Month 2	29 2012	
- 30	Examir		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Dear		4c. County of Deat	
	AL	×	Suburban Hospital 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday)	Bethesda If Under 1 Year If Under 24 Hrs		Montgomer	
8	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Usual Residence of Decedent 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs Months Days Hours Min		Year) Con	thplace (State or Foreign untry) SR
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Baltimore, Maryland	permit. Page 1 and 2 Department of Health Important: If item 2: any injury or other toonce,		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, cre	matory or other place)		20c. Location - City or	
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m	Depar Impor any in			91 Rockville Pike			
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Box 687	To the hospital or Attending Physicians. The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director, After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial completely filled in by the funeral director.	Physician/Me		Ectopic pregnancy Other (specify)		23d. Date of deli Month	very Day Year
P.O.	requires that the dex been signed by the s should be detached		Part II. Other significant conditions contributing to death but not resulting in the o	ınderlying cause given in Part I.	23e. Did toba	acco use contribute to	the cause of death?
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<u>ta</u>	sician; certific irector,	00	25. Was case referred to medical examiner? 1 Yes 2 X No	26. Place of Death (Chec			
<u>;</u>	y Physer this eral di	은 :	27. Manner of Death 28a. Date of injury 28b. Time of	at 3 DOA Street 4 Nursing H	ome 5 Residence	ce 6 Other (Specif	fy)
uc :	ath. r: Afte	icat	1 Natural 5 ☐ Pending (Month, Day, Year) injury 2 ☐ AccidentInvestigation	work? M 1 Yes 2 No	20d. Describe now	injury occurred	
Division of Vital	r Atte ter de recto	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm, str. building, etc. (Specify)	eet, factory, office	28f. Location (Stree	et and Number or Rura	al Route Number,
ă	ortal o				City or Town, S		
:	To the Hospital or Attending Physics in the Hours after death. To the Funeral Director: After this completely filled in by the funeral di	Medical	29a. Certifier (Check check only one) 3 Certifying Physician: To the best of my knowledge, death of only one) 3 Certifying Nurse Practitioner: To the best of my knowledge.	igation, in my opinion, death occurred a death occurred at the time, date and p	at the time, date and a	place, and due to the ca	ause(s) and manner stated
	2 ₹ 2 5		29b. Signature and title of certifier	29c. License number D0068160		d. Date signed (Month, -2-2012	Day, Year)
		-	30. Name and address of person who completed cause of death (Item 23a) (Type, F	rint)			
			Kimberly Zuzak - MD - 8600 old George	town Rd., Betheso	la, Maryla	and 20814	
	State Registra	е	31. Date filed (Month, Day, Year) 32. Registrar's Signature	dis.			
	negistra	_	MAR 12 2012 Come A. Add				

DHMH 17 Rev 06-2011

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Regular 20 2 0932																
			Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death									1 6				
	Physicia Medic		Lois P. F		,						onth 3/1/	2012	Year	3. Time of Death		
	Examir	er	4a. Facility Name (if n	, ,		/		4b. City, Town, o				4c. County o	f Death			
	Funeral		Anne Arun 5. Social Security Nur			ter 7. Age (In yrs. Ia	ast hirthday)	A If Under 1 Year	Annapolis ear If Under 24 Hrs. 8 Date of F			Anne				
	Funeral Director		577-34-24		1 □ M XX F	83	Yrs.	Months Days Hours Min.			8. Date of Birth (Month, Day, Year)			lace (State or Foreign ry)		
	J. M.		Usual Residence of						<u> </u>	7/	6/1928	3		MI		
	ryland -f sho	ctor		10b. County	. 1 1	10c. Cit	y, Town or Loc						10	Od. Inside City Limits		
	r 28a notif	Director	MD 10e. Street and Numb		runde1			Mayo			1 ☐ Yes XX No					
	with the 23a c		3908 Cala		RD				21106		100	g. Citizen of Wh		sa.		
	eath v tems er mu	Funeral	11. Marital Status	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	12. Was Dece	dent Ever in U.S		Vas Decedent of H	ispanic Origin	? (Specify Yes	or No-	14. Race				
21215-0036	should be filed within 72 hours after death with the Maryland nand Mental Hygiene. I sam arked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Examiner must be notified at	by	1 ☐ Never Married 3 🛛 XXVidowed 4		Armed For 1 Yes If Yes, Give Year or Da	2 XX Vo		Yes, specify Cuba		Puerto Rican, €	etc.)		White, e			
5-	72 hou "nate	plet	15. Decedent's Education (Specify only highest grade completed)				(Give k	ent's Usual Occup	ation during most of	f workina	16	b. Kind of Bus	iness/Ind	ustry		
121	ithin 7 ene. • than	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)			4 or 5+)	life. DC	NOT use retired)				JS Government Health				
9	iled w I Hygi othe rent, t	Be	17. Father's Name (First, Middle, Last)								e (First, Middle, Maiden Surname)					
/lar	d be f Venta arked itic ev	70	Lloyd M.	Peterso	n							Peter	son			
Maryland	ge 1 and 2 should be it of Health and Men if item 27 is marke or other traumatic		19a. Informant's Nam	ne/Relationship	(Type, Print)		19b. Mailin	g Address (Street a	and Number o	or Rural Route	Number, Cit	y or Town, Sta	te, Zip Co	ode)		
	nd 2 m 2; ier t		Mary Pears		ghter)			Calvert 1	Beach 1	Rd. St.	Leon	ard, M	D 20	685		
Baltimore,	permit. Page 1 ar Department of Hi Important: If iter any injury or oth		1 🛮 Kurial 2 🗆	Cremation 3	☐ Removal from		lace of Dispos emetery, crem	sition (Name of atory or other plac	· :	Date	i	c. Location - C	ity or Tov	vn, State		
Ē.	permit. Page Department (Important: If any injury or once,		4 ☐ Donation 5			Cu1		National		3/5/201		ulpepe:	r, V	A		
Ba	Depar Impor any ir		13- g	7.Ch	SHOCE		12	Name and Addres	Ave.	Hardest Annapo	ly Fun	eral H MD 2140	one,	P.A.		
	Physician Medical Examiner		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of): Approximate Interval Between Onset and Death PAT I													
		er	Sequentially list conditions, b. Acceptable to for as a purpose tuning a fix.									,	TEARS			
	red	Examiner	if any leading to immediately cause. Enter Underly Cause (Disease or inj	equence of):							i					
	cate be executed physician and s the burial-transit		that initiated events resulting in death) La													
09	te be o	edical	d													
687	rtificat ing ph e as th		IF FEMALE:		T			- 07				1				
Вох	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transi	Completed by Physician/M	23b. Was decedent pregnant in the past 12 months? 1								23d. Date Month		y Day Year			
P. 0.	ician: The law requires that the dec certificate has been signed by the a rector, page 2 should be detached	Ϋ́	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute								ute to the	cause of death?				
dS,	quires en sign ould br	edk	CHF, BREASTCA, A-F, b, PULMONARY HTM 1 XYES 2 NO									2 🗆 No 3	3 Probably 4 Unknown			
Sor	aw rec as bee 2 sho	plet								24:	a. Was an autopsy			sy findings available upletion of cause of		
Ř	The karate ha	Som								1 [performed Yes 2	1? dea	ath?	_		
=	ician: sertific ector,	Be	25. Was case referred to medical examiner? 26. Place of Death (Check only one)													
ţ	Physi this c	욘	1 Yes 2 1 27. Manner of Death	No	28a. Date	npatient 2 1	ER/Outpatient 28b. Time of		4 L_Nursir			6 Other (Specify)			
f Vita		2.5				injury work?						curred				
n of Vita	ding th. After fune	cate:		5 Pending	(Month	,,,,			Yes 2 No	\ I		Street and Number or Rural Route Number,				
ision of Vita	Attending ar death. ector: After by the fune	ertificate:	2 Accident 3 Suicide	Investigat 6 Could no	ion be 28e. Place of	of Injury - At hor			Yes 2 No	28f. Loc			or Rural Fi	Route Number,		
Division of Vital Records,	ital or Attending rs after death. al Director: After led in by the fune	Certificat	2 Accident	Investigat	ion be 28e. Place of			M 1 □	Yes 2 No	28f. Loc	ation (Street or Town, St		or Rural Fi	Route Number,		
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Division of Vita	o the Hospital or Attending within 24 hours after death. o the Funeral Director: After ompletely filled in by the fune	Medical Certificat	2 Accident 3 Suicide 4 Homicide	Investigat Could no determine Certifying Pl ledical Exa	28e. Place of buildin	of Injury - At hor g, etc. (Specify) st of my knowle	edge, death oc	M 1 : et, factory, office	, date and pla n, death occur	28f. Loc City	o the cause(s, date and place to the cause	s) and manner ace, and due to	as stated the caus	i. e(s) and manner stated.		
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Physician /Medical Examiner n and transit To the Hospital or Attending Physician: The law requires that the death certificate be executed

Physician

/Medical

Examiner

Funeral

Director

ral", or items 23a or 28a-f shore Experience must be notified at

Director

Completed by Funeral

Be

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant of Health and marked other than "natural", or items 23a or 28a-f show

Department of Health and Mental Hygiene. "natur Important: If Item 27 is marked other than "natur any injury or other traumatic event, the Medical once."

21215-0036

Maryland

Baltimore,

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MARCH

Division of Vital Records, P.O. Box 68760,

- 1	disease or condition resulting in death)	a. 29515											
aminer	resulting in deathy	Due to (r as a consequ	0.00										
	Sequentially list conditions,	b respirato	ry faily	rt									
	if any, leading to immediate cause. Enter Underlying	Due to (or as a consequ	ence of):										
	Cause (Disease or injury that initiated events	ascites											
	resulting in death) Last	Due to (or as a consequ	ence of):				-						
		d. cholangio carcinoma											
ğ		0.	, , , , , , , , , , , , , , , , , , , ,				·						
Iysıcıdırımı	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnar 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de 9 ☐ Unknown	death 3 Ectopi		23d. Date of delivery Month Day								
Ē	Part II. Other significant conditions of	ontributing to death but not resu	Iting in the underlying	cause given in Part I.		o use contribute	to the cause of death?						
2	congestive heart	congestive heart failure with ejection fraction 25-30% 10 yes 20 No 30											
			-		1 100								
5		24a. Was an autopsy											
5			performed? 1 □ Yes 2 □										
2	25. Was case referred to medical examiner?	26. Place of Death (Check only one)											
5	1 Yes 2 No	Hospital: 1 Inpatient 2 □ E	6 ☐ Other (Specify)										
allon.	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day, Year)	f Injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred										
	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hor building, etc. (Specify	me, farm, street, facto	ory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)								
Culcal	29a. Certifier (Check only one) Certifying Ph 2 Medical Example	ysician: To the best of my know niner: On the basis of examinat and manner stated.	vledge, death occurr ion and/or investigati	ed at the time, date and place on, in my opinion, death occ	ce, and due to the cause curred at the time, date a	(s) and manner a and place, and du	as stated. le to the cause(s)						
Ě	29b. Signature and title of certifier	7	2	29d. [Date signed (Mon	th, Day, Year)							
	m. meh	and De	>_	H72/43	Ma	March 6,2012							

DHMH 17 Rev 1/2001

State

Registrar

Mohammad 31. Date filed (Month; Day, Year)

within 24 hours after death To the Funeral Director:

9901 Medical Center Drive,

rockville, Manyland 20550

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mehmood, Do

MAR 12 2012

32 Registrar's Signature

HUNTER JON L 2/8/12 0420 Division of Vital Records, P.O. Box 68760

				Please	Type or P							-		_	ble.			
			For State Registrar		State of r	Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 7								0.0	10	0.0	223	
	Physicia Medi		1. Decedent's Name (Fin		2. Date o Month Marc					Death Say Year 3.			3. Time of 1					
in and	Exami		4a. Facility Name (if not					4b. City, Town, or Location of Death Bethesda					4c. County of Death Montgomery					
94	Funeral Director	tor 220-50-9740 1X M 2 D F 63						If Under 1 Year If Under 24 Hrs. 8. Date of Months Days Hours Min. (Month,										
	laryland Sa-f show iffied at	Director	Usual Residence of De 10a. State 10b MD MD	ry	10c. City, Town or Location Bethesda				04/11/	174			d. Inside City					
	ith the M 23a or 28 at be not	ral Dir	10e. Street and Number		00t									Citizen of W		,		
21215-0036	is filed within 72 hours after death with the Maryland tal Hygiene. ad other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	ed by Funeral	4523 Traymore Street 11. Marital Status 1					20814 U1 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □ Yes 2 ☒No Specify:							14. Race - American Indian, Black, White, etc. Specify: White			
	led within 72 hou Hygiene. other than "natu ent, the Medical	To Be Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)					16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Statistician					16b. Kind of Business/Industry Federal Government					
land 2	be filed w ental Hygi ked othe c event, t		17. Father's Name (First, Thomas Wil		nter							e (First, Middle			,			
Baltimore, Maryland	of and 2 should be file of Health and Mental F fitem 27 is marked of rother traumatic ever		19a. Informant's Name/I	Relationship (Typ	e, Print)	er	1	Henrietta Hinrichsen ing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3 Traymore Street Bethesda, MD 20814							-			
	permit. Page 1 and Department of Hea Important: If item any injury or othe		20a. Method of Dispositi 1 ☐ Burial 2 文C 4 ☐ Donation 5 ☐	remation 3 🗆 I	Removal from Stat	e c	Place of Dispos cemetery, crem tional	sition (Na natory or Cre	me of other place mator	;) 'Y	3-10	Dete 0-2012	20c. Fa	Location - C	ity or Tow hurch	, VA		
Bal	Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Departition Depart		21. Signatury Funeral	allow	1		5	130	Wisco	nsin	Ave	eph Gaw • NW Wa	shi					
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Acute Stroke with Hemorrhagic Conversion Due to (or as a consequence of):											Approximate Interval Betwo Donset and De Days							
	an and rial-		Sequentially list conditions, if any, leading to immediate cause. Enter Uniderlying Cause (Disease or injury that initiated events c.															
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). Box 68760	o the hospital or Attending Physician: The law requires that the death certificate be evitin. At a burns after the cash, within 24 burns after death. To the Funeral Director. After this certificate has been signed by the attending physicial completely filled in by the funeral director, page 2 should be detached for use as the burns.								200.0.0.0					23d. Date of delivery Month Day Year				
ds, P.C	requires that i been signed b should be det													tobacco use contribute to the cause of death? Yes 2 Mo 3 Probably 4 Unknown				
Division of Vital Records, P.O.	sician: The law recterificate has be													as an 24b. Were autopsy findings availat topsy rformed? so 2 ♣ No 1 □ Yes 2 □ No			ailable ise of	
/ital	sician	0	25. Was case referred to examiner? 1 ☐ Yes 2 🏋 No	Tu.	ospital:	26. Place of Death (Che						ck only one) Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred						
n of V	ding Physician: 1 th. After this certifica funeral director, p	cate: To	27. Manner of Death 1X Natural 5	Pending	1 ☑ Inpatient 2 ☐ ER/Outpatien 28a. Date of injury (Month, Day, Year) 28b. Time of injury			28c. Injury at work?			2							
Divisio	Io the Hospital or Attending I within 24 hours after death. To the Funeral Director; After Completely filled in by the funer	Certificate:	2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 6 ☐ Could not be be determined 7					M 1 ☐ Yes 2 ☐ No et, factory, office 28f				28f. Location (Street and Number or Rural Route Number, City or Town, State)						
_	ne Hospii in 24 hour he Funera ipletely fill	Medical	(Check 2 L IV	nedical Examine	cian: To the best o er: On the basis of Practition or: To U	examination	and/or investig	nation, in	my opinion	, death occ	curred at t	he time date a	nd place	and due to	the cause	(s) and mann	er stated.	
	To to t			9b. Signature and title of certifies									29d. Date signed (Month, Day, Year) 03/08/2012					
			30. Name and address of Eric Park		Old Geo	rgeto	wn Road	d Be	thesd	a, MI	208	314						
	Stat Registra		31. Date filed <i>(Month, Day</i>	y, Year) 2 2012	82. Registr	ar's Signati	ure back	S.										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ ERNEST MARCH HOCKENBERRY 2019 10:12a м Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK If Under 1 Year | If Under 24 Hrs. Social Security Number Age (In yrs. last birthday) **Funeral** 8. Date of Birth Birthplace (State or Foreign Country) Months Days Hours 03/13/1943 **Director** 68 206-34-2185 PA Usual Residence of Decedent show 10a. State 10b. County death with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits "natural", or items 23a or 28a-f s edical Examiner must be notified 1 X Yes 2 No Frederick Brunswick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1106 2nd Ave. 21716 USA 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?
1 ☑ Yes 2 ☐ No 1 X Never Married 2 Married Black, White, etc. Completed by Baltimore, Maryland 21215-0036 be filed within 72 hours after 1 ☐ Yes 2 🖾 No Specify: If Yes, Give 3 Divorced Specify Year or Dates. 1962-64 White permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important If item 27 is marked other than "natur any injury or other traumatic event, the Medical. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) trucking Truck Driver Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Ernest Dove Geraldine Hockenberry 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Leslie Waite/step-daughter 4305 Ferry Hill Ct., Point of Rocks, MD 21777 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Stauffer Crematory 03/10/2012 | Frederick, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stauffer Funeral Homes, P.A. ▶ 1621 Opossumtown Pike, Frederick, MD 21702 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Ph_{sician} Onset and Death disease or condition resulting in death) Medical Due to or as a consequence of) Examiner 10 day OWITCH Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): The law requires that the death certificate be executed and -trar Due to (or as a consequence of): resulting in death) Last physician a sthe burial-Physician/Medical Box 68760 attending pl IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy5 ☐ Other (specify) ___ in the past 12 months? Pregnant at time of death Month Day Year signed by the a d be detached f Yes 2 No g Unknown Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Renal Failure Division of Vital Records, Completed 1 🗖 Yes 2 🗆 No 3 🗆 Probably 4 🗆 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performe Yes 2 No Hospital or Attending Physician: 25. Was case referred to medica Be 26. Place of Death (Check only one) 2 🕅 Ño Other: မ 1 Tyes 1 Npatient 2 ER/Outpatient 3 DOA After this 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No after death. Director: Af Accident Investigation M the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined building, etc. (Specify) 24 hours Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

within 2

Registrar

(Check

29b. Signature and title of certifier

Marius

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Marius Nillum MD Hin Was-

Registrar's Signature

NI

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number 072

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year ohn Carl Harris 8:25 PM Feb 2012 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death University Maryland Medical Center 1timone Baltimore City Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth Months Days Hours Min. (Month, Day, Year) Director 219-78-5066 1 **⋒** M 2 □ F Oct.5,1957 54 Virginia 28a-f show 10b. County 10a. State permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits 1 Yes 2 No Maryland Prince George's Bowie 6 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a Funeral 12615 Kavanaugh Lane 20715 USA Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, Armed Forces Black, White, etc. 1 Never Married 2 Married Completed by ☐ Yes 2 Mo Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ■ No Specify: 3 Widowed 4 Divorced Specify Year or Dates White other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event; the Me once. Elementary/Secondary (0-12) College (1-4 or 5+) Self Employed Appliance Repair Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) ဂ LeRoy Souder Harris Ruth Irene Collins Harris 19a. Informant's Name/Relationship (Type, Print) Mother 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ruth Irene Collins Harris 122 West Haven Drive, Statesville, NC 28625 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Cemeten, repator, or cher place Metropolitan Crematorium, Inc. 03/02/2012 Alexandria, Virginia 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Uneral Service Licenses 22 Name and Address of Facility
Molesworth-Williams, P.A., Funeral Home
26401 Ridge Road, Damascus, MD 20872 M01393 Part 1. Enter the digease, or complica consthat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Onset and Death Physician/ Necrotizin disease or condition resulting in death) forceatitis Medical Due to (or as a consequence of **Examiner** intestinal Seque tially list to cities if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) espirator Exami as the burial-trai that initiated events resulting in death) Last Due to (or as a consequence of) ed by the attending physician detached for use as the buria To the Hospital or Attending Physician: The law requires that the death certificate be ewithin 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicial completely filled in by the funeral director, page 2 should be detached for use as the bound Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Day Pregnant at time of death 5 Other (specify) Month Year 1 Yes 2 g Linknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 | No မ 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at work?
1 ☐ Yes 28d. Describe how injury occurred **⊠** Natural injury 5 Pending 2 🗆 No 2 Accider
3 Suicide Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one)

0 State Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Hashim

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

WOELSAN

29c. License numbe

29d. Date signed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
Amend #3 per med cert G926 4/18/12 dk
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 12 Day Physician/ 2012 13:30 P M March Jerry W. Hewitt Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Harford de Grace Harford Memorial Hospital <u>Havre</u> 8. Date of Birth 9. Birthplace (State or Foreign Country) North Carol: . Age (In yrs. last birthday) Funeral Social Security Number (Month, Day, 09/27 1**X** M 2 □ F Hours Min. Director 75 Carolina 240-46-9545 Usual Residence of Decedent show 9464545 - 30D = 03/12/2012 = 13330PBaltimore, Maryland 21215-0036 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Examiner must be notified 28a-f 1 🗆 Yes 2 🔀 No Havre de Grace MD Harford 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or Funeral 21078 U.S.A. 500 Robinhood Road items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black, White, etc. "natural", or ve Korean þ 1 Never Married 2 Married 1 X Yes 2 If Yes, Give 1 ☐ Yes 2 No Specify: Specify: Mear or Dates. Vietn. 3 Divorced 4 Divorced Completed White traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Civil Serice Government and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Myrtle Baker Anderson Bergan Hewitt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once. 500 Robinhood Rd., Havre de Grace, MD 21078 Elisabeth Hewitt (Wife) 545694045 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1
Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 3/17/2012 West Chester, PA Ferris&Co.,Inc 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Zellman Funeral Home, P.A. S.Washington St., Havre de Grace, MD emplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. r art 1. Enter the disease, or shock, or heart failure. List only Approximate Interval Between Onset and Death Immediate Cause (Final arrothmi Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to jor as a conse juence of attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day Month Year n signed by the a Id be detached f Yes 2 No g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 \square Yes 2 \square No 3 \square Probably 4 \square Unknown has been signed by 2 should by 24b. Were autopsy findings available prior to completion of cause of autopsy page death? perform this certificate 2 🔲 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) funeral director examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗆 No မ 1 Yeş 1 Inpatient 2 I ER/Outpatient 3 I DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred the Hospital or Attending I thin 24 hours after death. Matural 5 Pending hours after death. neral Director; Aft d filled in by the fur 1 Yes 2 No Accident Investigation 2 Acciden 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) ess of person who completed cause of death (Item 23a) (Type, Print) Sign 30. Name and and J90 501 State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ HAU UEI INE Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Mandrin House Anne Arundel Harwood If Under 24 Hrs. Hours Min. Social Security Number 6. Sex Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Director 577-50-5916 77 1 □ M 2**2**2 02/24/1935 Wash.,D.C. Usual Residence of Decedent or 28a-f shov 10a. State 10c. City, Town or Location 10d. Inside City Limits must be notified at Director 1 X Yes 2 ☐ No Md. Prince George's Beltsville 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? Funeral or items 23a 5436 Odell Road 20705 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Examiner Armed Forces?

1 Yes 2 No Black White etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Specify: Black If Yes, Give "natural", Completed 3 ₩idowed 4 □ Divorced Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry
Dept. of Agriculture within 72 Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) U.S. Government aboratorv Assistant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F 2 William Haig Ethel Harrison 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27 Katherine T. Crawford/Sister 4614 South Dakota Ave., N.E., Wash. D.C. 20017 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or otl 1 🙀 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Maryland Nat'l. Mem. Pk. 03/13/12 Laurel, Maryland Signature of Funeral Service Licenses 22. Name and Address of Facility Henry S. Washington & Sons Co., Inc. rall CC0316 4925 Burroughs Ave., N.E., Washington, D. 20019 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician. UNG disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner Due to (or as a consequence oi) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last physician Physician/Medical that the death certificate be Division of Vital Records, P.O. Box 68760 the as IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ō in the past 12 months?
1 Yes 2 No Month Dav 5 Other (specify) Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy Hospital or Attending Physician: The certificate Yes 21 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 No မ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Spec within 24 hours after death.

To the Funeral Director: After this
Completely filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No М Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Vertifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the I only one 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 06-2011

Registrar

A Name and address of perso

JENEUIEVE

Pate filed (Month, Day, Year)

HWY, ANNAPOLIS, M.D. 21401

(Item 23a) (Type Print)

ho completed cause of death

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2, Date of Death JONES 529 AM Physician/ MARCH 201 Medical or Location of Death 4c. County of Death Name (if not institution, give street and number, City, Tov **Examiner** 8 Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Min Director 579-40-9141 1 □ M 2 🕅 F Yrs 79 December 24, 1932 0klahoma Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location with the Maryland notified at Director 1 X Yes 2 No North Myrtle Beach SC Horry 10f. Zip Code 10e. Street and Number 10g, Citizen of What Country? ò iral", or items 23a o Examiner must be Funeral 29582 USA 2009 Perrin Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Force Black, White, etc. þ 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 X No Specify. Specify: If Yes. Give "natural", White Completed 3 X Widowed 4 Divorced Year or Dates the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Prince George's alth and Mental Hygiene. 27 is marked other than r traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) School Board 12 Secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 (unavailable) Rella McDowell 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 650 Woodland Way, Owens, MD 20736 Teddy L. Jones / Son Department of Health Important: If item 27 any injury or other to once. 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 3/13/2012 Alexandria, Virginia Metropolitan Crematory 4739 Baltimore Avenue 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Ahnin Gasch's Funeral Home, P.A. Hyattsville, MD 20781 23a. Part 1. Enter the disease, or complications that caused the death. Do of enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Ph_sician/ Aute renal failure disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** infection and poor energy intake Esquentiary list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) nding physician and use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) the i a | Unknown ed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performe 1 ☐ Yes 2 ☐ No certificate Yes 2 26. Place of Death (Check only one) 25. Was case referred to medical Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ြု 1 🗌 Yes 1 Mnpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury at work?
1
Yes Certificate: Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After of completely filled in by the funer injury 1 Natural 5 Pending Investigation Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and 2 MARCH 11 2012 RES-00 0

Registrar

State

5 more MD 2128

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

MO

Rina Khatri

. Date filed (Month, Day, Year)

12-02121 Helen Johnson Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

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Physicia		1- For State Registrar	Certificate of Dea		Reg.	No.	
al Exami	an/ ner	1. Decedent's Name (First, Middle,Last) Helen Clemite	ene Johnson	:	2. Date of Death Month Da	ay Year	3. Time of Death 1844 hrs
		4a. Facility Name (if not institution, give street and nun Southern Maryland Hospital		r, Town, or Location of Death	March 13, 20	4c. County of Death Prince George	
Funeral Director		5. Social Security Number 6. Sex 1 M 2 X F		nder 1 Year If Under 24Hrs.	8. Date of Birth (N	//////////////////////////////////////	
, any		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Location				10d. Inside City Limi
rland -f show once.	tor	District of Columbia	Washingto				1 X Yes 2 1
the Mary a or 28a stiffed at	Director	10e. Street and Number 138 Darrington Street,		Zip Code 20032		Citizen of What Coun United Sta	Ĭ
items 23	Funeral	1 Never Married 2 Married Armed For		dent of Hispanic Origin? (Spe cify Cuban, Mexican, Puerto F		14. Race - Americ White, etc.	an Indian, Black,
after d	by Fi	3 Widowed 4 Divorced If Yes, Give Yeer or Dates:	1 Yes	2 X No specify:		Specify: Bla	
and 2 should be filed within 72 hours after death with the Maryland lealth and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f she traumatie event, the Medical Examiner must be notified at once	Completed	15. Decedent's Education (Specify only highest grade Elementary/Secondary (0-12) College (1- 2 years	4 or 5+) during most of w	al Occupation (Give kind of wo vorking life. DO NOT use retire Practical Nurs	ed)	b. Kind of Business/Ir Hadley Me Hospital	emorial
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2 shou h and N 27 is n	-	Lizzie L. Harrison (Daug		ington Street,			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 10:05a March 10,2012 Lillian Kerner Physician/ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Rockville Montgomery Hebrew Home of Washington 9. Birthplace (State or Foreign NewntryYork 8. Date of Birth 7. Age (In vrs. last birthday) Social Security Number 054-09-2124 **Funeral** 1 □ M 2 🖾 F Months Hours 1 294 9 12 99 Director Usual Residence of Decedent show 10b. County 10d. Inside City Limits 10c, City, Town or Location 10a. State ral", or items 23a or 28a-f sho Examiner must be notified at Director Rockville Montgomery 1 ☐ Yes 2 No MD 10f. Zip Code 20852 10a, Citizen of What Country? 10e. Street and Number Funeral 6121 Montrose Road USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) death 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces? Black, White, etc. ģ 1 Never Married 2 Married filed within 72 hours after Baltimore, Maryland 21215-0036 1 Ves 2 No White Specify. If Yes. Give "natural", Completed 3 X Widowed 4 Divorced Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. ant: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) Retail Sales Sales Person other traumatic event, Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Faigel Nozick Kalman Epstein 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Columbia, 19a. Informant's Name/Relationship (Type, Print) 10101 Governor Warfield Parkway#105 Rita Kerner/Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition cemetery, crematory or other place)

Beth El Cemetery 1

■ Burial 2
□ Cremation 3
■ Removal from State 4
□ Donation 5
□ Other (Specify) injury or Department of Important: If any injury or 3/13/2012 TWNSHP of Washington, PHTETP TO REMALDI FUNERAL SERVICE, P.A. 9241 Columbia Blvd. Silver Spring, Md20910 21. Signature of 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on the spiratory arrest, shock, or heart failure. Interval Between Onset and Death Immediate Cause (Final eu Physician/ disease or condition 2 Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of). Cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last and Due to (or as a consequence of): burial ate has been signed by the attending physician page 2 should be detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: ves, outcome of pregnancy
Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) Day in the past 12 months? Month Year To the Hospital or Attending Physician: The law requires that the death Pregnant at time of death 1 | Yes 2 | 9 | Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 2 X NO 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed Yes 2 death? 2 🗆 No Yes After this certificate within 24 hours after death.

To the Funeral Director: After this certification by the funeral director, to 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Dav. Year injury work? 1 ☐ Yes 2 ☐ No 5 Pending 1 Natural Investigation Accident 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one

State Registrar

DHMH 17 Rev 7/2009

29b. Signature and title of certifier

31. Date filed (Month, Day, Year NAR 12

30. Name and address of person who com

SH

Year,

2012

eted cause of death (Item 23a) (Type, Print)

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death 26, Physician/ 2012 February 3:15p Medical William Keyser 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Frederick Northampton Manor Nursing Home Frederick Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8 Date of Birth Social Security Number 6 Sex **Funeral** (Month, Day, Year) Director 215-78-8877 1 🖾 M 2 🗆 F Feb. 8, 1930 Maryland 82 Usual Residence of Deceden 28a-f show 10d. Inside City Limits items 23a or 28a-f sho her must be notified at 10a. State 10b. County 10c. City, Town or Location Director 1 X Yes 2 No Maryland Frederick Frederick 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 200 East 16th Street 21701 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 11. Marital Status 14. Race - American Indian. event, the Medical Examiner Black, White, etc. 9 þ 1 X Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: "natural", 3 Widowed 4 Divorced Completed White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) 0 Not applicable None Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Claude Kevser Emma Summerfield 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 is n any injury or other transconce. Ann Verbeten/ Friend 9434 Birchwood Lane, Frederick, Maryland 21701 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place) Stauffer Crematory Inc.3/6/2012 4 ☐ Donation 5 ☐ Other (Specify) Frederick, Maryland. 22. Name and Address of Facility Stauffer Funeral Homes P. A. 1621 Opossumtown Pike, Frederick, Maryland 21702 21. Signature of Mineral Service 23a. Part 1. Enter the disease, or complications hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one callseyon each line. retardation Onset and Death Immediate Cause (Final Physician/ menta disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying eizures Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? 1 Yes 2 No Month Day Year 1 Yes 2 4 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ aspiration preumonias 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 📈 Unknown Completed dysphagia 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an performed? Yes 2 N 1 ☐ Yes 2 🗷 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 Yes 2 No 28b. Time of Certificate: 28d. Describe how injury occurred To the Hospital or Attending 1 Natural 5 Pending 2 Accident 3 Suicide 4 Homicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a To the Funeral L

State Registrar

Medical

29a, Certifier

only one) 29b. Signature and tit

31. Date filed (Month

of certifie

Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

32. Registrar's Signature

Nagu

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Sertifying Nurse Pragititioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

D0055061

300 West Nint St, Frederick MD 2170

12-02047 Devin Edmond La Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Devin Edmond Last	er State of M 1-For State Registrar	Maryland / Departn <i>Certifi</i> o	nent of Health ar cate of Death		Reg. No. 2012	0933
Physician/	Decedent's Name (First, Middle,Last)	HDMONED	TACMED	2. Date of De Month	Day Year	3. Time of Death 1215 hrs
Medical Examiner	DEVIN 4a. Facility Name (if not institution, give street)	EDMOND	LASTER	March 1	1, 2012 4c. County of Death	12101110
	4610 Ridge Road	st and number)	Mount Airy		Carroll	
Funeral	Social Security Number 6. Sex	7. Age (In yrs. last b			Birth (MM/DD/YYYY) 9. Birt	
Director	325-80-7211 ₁ X _M	2□ F 33	Yrs. Months Da	ys Hours Min. 02 0		intry) Illinois
	Usual Residence of Decedent					10d. Inside City Limits
м воу	10a. State 10b. County D.C.	10c. City, Tow Wash	vn or Location nington			1 Yes 2 No
/land			10f. Zip Code		10g. Citizen of What Cour	
the Maryland tor 28a-f sh tiffied at one Director	10e. Street and Number 2501 Wisconsin NW Ap	t # 403	20007		United State	-
ath with the Maryland items 23a or 28s-f sho sst be notified at once ineral Director		Was Decedent Ever in U.S.		ispanic Origin? (Specify Yes or I		
r death with or items 23 c. must be no Funeral	1 X Never Married 2 Married	Armed Forces? X Yes 2 No		n, Mexican, Puerto Rican, etc.)	White, etc.	
s after d	3 Widowed 4 Divorced If Yes	, Give Year	1 Yes 2 X N	o specify:	Specify: B1	ack
nours a	15. Decedent's Education (Specify only hig	,	 Decedent's Usual Occupation during most of working life 	ation (Give kind of work done e. DO NOT use retired)	16b. Kind of Business/I	ndustry
36 In 72 h han ", lical H	Elementary/Secondary (0-12)	College (1-4 or 5+)	Waiter		Hospitality	
5-0036 ed within 72 hour ed within 72 hour bygiene. other than "natu the Medical Exan Completed	17. Father's Name (First, Middle, Last)	, i	-	18.Mother's Name (First, Middle		
215-0036 be filed within 72 hours af ntal Hygiene. rked other than "natural ent, the Medical Examin Be Completed by	Benjamin Laster			Deann Hawki	ns	
more, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after death with the Maryland rent of Health and Mental Hygiene. Not: If item 27 is marked other than "natural", or items 23a or 23a-f she or other traumatic event, the Medical Examiner must be notified at once Tobbe Tobbe 1 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to 10 to	19a. Informant's Name/Relationship (Type, F	, ,		eet and Number or Rural Route N	•	Zip Code)
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ore, salan of Hea	20a. Method of Disposition 1 X Burial 2 Cremation 3 Re		e of Disposition (Name of control of control or other place)	emetery, Date	200. Location - City of	Town, State
Page ment of taot:	4 Donation 5 Other Specify:	Nationa	al Memorial Parl		Falls Chur	ch, Va.
Baltimore, MC permit. Pages 1 and 2 s Department of Health a Important: If item 27 injury or other traum	21. Signature of Funeral Service Licensee	mall 3	22. Name and Addres Danzansky-Go	ss of Facility oldberg Memorial Ch Rockville Pike, Rock	apels.Md. 20852	
Physician	23a, Part I, Lanter the disease, or complication	ns that caused the death. Do				Approximate Interval
/Medical	failure. List only one cause on each lin Immediate Cause (Final disease a. 0x)	_{e.} vcodone Intoxi	cation and c	ocaine use		Between Onset and Death
xaminer		o (or as a consequence of):				
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ine	if any, leading to immediate Due to cause. Enter Underlying Cause	o (or as a consequence of):				
Z A Z	(Disease or injury that initiated events resulting in death) Last	o (or as a consequence of):				
to, e be executed ysician and burial - transit ledical Examine	d.	ENDED 23a , 27 , 28a	ef per me co	25 3-29-12 cm		
10, e be ex ysician burial					23d. Date of delivery	
b. Box 6876 the death certificate by the attending phy locked for use as the Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	c. If yes, outcome of pregnand Live birth	₂ Fetal death 3	Ectopic pregnancy	The second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second secon	ay Year
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Division of Vital Records, P.O. Box 6876 tal or Atteodiog Physiciao: The law requires that the death certificat its after death. al Director: After this certificate has been signed by the attending phied in by the funeral director, page 2 should be detached for use as the artification: To Be Completed by Physician/M			, ,		es 2 No 3 Prob	ably 4 🗸 Unknown
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Di Hospital 24 hours : Funeral stely filled	4 Homiciae		t a friend's	Mount	Airy.Md.	
Division of Vital Records, P.O. Box 68766 To the Hospital or Atteodiog Physiciae: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the by Medical Certification: To Be Completed by Physician/Medical Certification:	29a. Certifier (Check only one) 2 Medical Examiner: On t	o the best of my knowledge, on the basis of examination and/o	death occurred at the time, or investigation, in my opinion	date and place, and due to the ca on, death occurred at the time, da	iuse(s) and manner as state te and place, and due to th	au. e cause(s)
To T To t To t Med	29b. Signature and title of certifier	manner stated.		nse number	29d. Date signed (Mod	
6-PENE	1/11/11/1	1./) 0.0	.M.E. OCME	March 12, 2012	
	30. Name and address of person who compl				1	
		Assistant Medical Exa		more Street, Baltimore, I	MD 21223	
State		32. Registrar's Signature	backs.			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 3 Physician/ 2012 Caleb Michael Lewis 1711 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll Westminster Carroll Hospital Center . Social Security Numbe 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Min. (Month, Day, Year) Months Hours 216-87-6609 Maryland Director Usual Residence of Decedent or 28a-f show notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Westminster 1 Yes 2 No MD Carroll 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9 and Mental Hygiene. is marked other than "natural", or items 23a or raumatic event, the Medical Examiner must be r Funeral 21157 USA 302 Bishop Court Page 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Force Black, White, etc 1 Never Married 2 Married þ Yes 2 No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Specify: white 3 🗌 Widowed 4 🗌 Divorced Completed Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) N/A N/A 0 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Rebekah K. Adamez ပ Jeffrey A. Lewis other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 302 Bishop Court, Westminster, MD 21157 Rebekah K. Lewis, mother 20a. Method of Disposition 20b. Place of Disposition (Name of Came of Came of Length Change) 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1 Burial 2 Cremation 3 Removal from State 3/9/2012 Finksburg, MD 4 Donation 5 Other (Specify) of God Cemetery Signature of Funeral Service Licenses 22. Name and Address of Facility Myers-Durboraw Funeral Home 91 Willis Street, Westminster, MD 21157 Part 1) Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate or heart failure. List only one cause on each line Interval Between Immediate Cause (Final complications Holoprosencephaly Ph_sician/ disease or condition resulting in death) life long Medical Due to (or as a consequence of) Examiner life long omplications Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Exami use as the burial-transi and that initiated events Due to (or as a consequence of): resulting in death) Last physician Physician/Medical that the death certificate be Division of Vital Records, P.O. Box 68760 attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year Pregnant at time of death 4 Pregnant a Yes 2 No 1 | Yes 2 L 9 | Unknown the been signed by the should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Tracheostomy Dependent 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes director, page 2 should Dependent 24b. Were autopsy findings available prior to completion of cause of G-tube 24a, Was an autopsy performe developmental delae After this certificate I Severe 1 ☐ Yes 2 ☐ No • Hospital or Attending Physician: 1 24 hours after death. • Funeral Director: After this certifica 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? 2 🗹 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဂ 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral a 27. Mann of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred ▶ Natural 5 Pending injury 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check

State Registrar wither Erldann

ROLDAN

CYNTHIA

31. Date filed (Month, Day, Year) MAR 0 8 201

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

200

32. Registrar's Signature

ASSLA.

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MEMORIAL AVENUE.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

D 62633

WESTMINSTER

29d. Date signed (Month, Day, Year)

2012

21157

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 5013 0549 MAI 0001615 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Lacation of Deat County of Death Examiner アで JUE C. W 10C If Under 24 Hrs 8. Date of Birth Birthplace (State or Foreign Country) Funeral Months June 3 005-20-6955 1 X M 2 🗆 F Hours 84 1̈́927 Maine Director Usual Residence of Decedent show 10d. Inside City Limits 10a. State 10c. City, Town or Location 72 hours after death with the Maryland notified at Director 28a-f 1 Yes 2 XNo Prince George's Ft. Washington Marvland 10e. Street and Number 10g. Citizen of What Country? ō er than "natural", or items 23a or the Medical Examiner must be Funeral 3208 20744 USA Calvdon Court 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, 11 Marital Status Armed Forces? Black, White, etc orces? 2 No 1945— ve 1946 ates. XX Yes þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes XX No Specify White If Yes, Give Year or Dates. Specify: Completed 3XX Widowed 4 ☐ Divorced 15 Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Federal Judge Claims Court Justice Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic eve ပ Conroy John Lydon Annie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Catherine R. Mack / Attorney 7315 Wisconsin Ave. #800W Bethesda, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Resurrection Cem. 03/15/2012 Clinton, Maryland 4 Donation 5XX Other (Specify Entombent 22. Name and Address of Facilit George P. Kalas Funeral Home PA /WL 6160 Oxon Hill Rd. Oxon Hill, Maryland 23a. Part VEnter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): burial attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown the 1 Li Yes 2 L 9 Li Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed been si Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2 🗆 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify ဂ္ဂ 28d. Describe how injury occurred ~ ~ R, 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 1 Natural
2 Accident 5 Pending 1 Yes 400 Investigation Sep 23 2011 completed filled in by the 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 17 (5 5 5 5 7 17 17) 4 Homicide determined Brockview Rd+ Old for K 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause (Mariner a diagram) 2014 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time date and place and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) nature and title of certi 29d, Date signed (Month, Day, Year) 4 mar

Registrar

State

31. Date filed (Month, Day, Year)

10

DHMH 17 Rev 7/2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RASSU

Kathleen Marie Milstead

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

past 12 months? A	or any ty Limits
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10a. State 10b. County 10c. City, Town or Location 10c. City, City, City, Indicate, Location, City,	? ☐ No
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Was decedent pregnant in the past 12 months? 1	
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and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)	
O.C.M.E. OGME March 20, 2012	
Thodore the kind how. D.	
30. Name and address of person who completed cause of death (Item 23a) Thoughout M. King, Jr. M.D., Assistant Modical Examiner, 900 W. Baltimore Street, Baltimore MD 21223	
Theodore M. King, Jr., MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223	
State 31. Date filed (Month, Day, Year) Registrar 32. Registrar Signature	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Physician/ **Eleanor** Mintzer 8, 5:00P M 2012 March Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Rockville Hebrew Home of Greater Washington If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (*In yr*s. **84** Funeral Months Hours 1 🗆 M 2 🕱 F Days April 18, New York Director 050-20-4438 10c. City, Town or Location 10d. Inside City Limits 28a-f shov should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 93a or 98a-1 en-natural", or items 93a or 98a-1 en-natural". 10a. State ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at Director 1 X Yes 2 ☐ No Bethesda Maryland Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States of America Funera 20817 7420 Westlake Terrace Unit 210 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc 1 Never Married 2 Married þ Specify: Caucasian Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: 3 XWidowed 4 ☐ Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Catering Business Owner Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Rose Gruskin Benjamin Savin t. Page 1 and 2 should be tment of Health and Men rtant: If item 27 is marke 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 10921 Candlelight Lane, Potomac MD Jodi Krame, Daughter Department of Health Important: If item 27 any injury or other tr 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Garden of Remembrance 03/11/2012 Clarksburg, MD 22. Name and Address of FacilityHines-Rinaldi Funeral Home, Inc 21. Signature of Funeral Service Licensee 11800 New Hampshire Ave. Silver Spring MD 20904 23a. Part 1 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition Pnysician/ Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to p as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2
Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy , ned by the attent detached for u in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) g 🗌 Unknown cate has been signed by page 2 should be detack Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Certificate: To Be Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed 2 🗆 No 1 🗌 Yes After this certificate 26. Place of Death (Check only one) completed filled in by the funeral director, 25. Was case referred to medical examiner? Other: Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural injury work? 5 Pending 1 ☐ Yes 2 ☐ No Investigation Accident Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical

within 24 hours after death.

To the Funeral Director; A

BENSON eted cause of death (Item 23a) (Type, Print) 30. Name and address of person who comp 31. Date filed (Month, Day, Year) Registrar's Signatu State MAR 12

Registrar

29a. Certifier

only one)

3

29b. Signature and title of certifier

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

5168

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#19a, perFH, G926, 4/5/2012 WS
State of Maryland / Department of Health and Mental Hygiene

		•	For State Registrar	Certificate of Dea	ath	Reg.	No. 201	2	093	337
П	Physicia		1. Decedent's Name (First, Middle, Last)			2. Date of Death March 8,	Day 012 Yea	ar I	. Time of De 2:09	
بالماملو	Medic Examir		Theodore Margolis 4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Loc		Harch 0,	4c. County of D	eath		A
الموسي		И	Fernbrook Assisted Living 5. Social Security Number 6. Sex 17. Age (In vrs. last.)	Odenton birthday) If Under 1 Year If I	Hadar 24 Hrs. La	D. L. EDINI	Anne A			
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last in 132-20-5203 1 1 ★ 2 □ F 81		lours Min.	B. Date of Birth (Month, Day, Yea	ar)	Country)	e (State or F	oreign
24	nd now	Ļ	Usual Residence of Decedent 10a. State 10b. County 10c. City. To	Town or Location	_ A	pril 28,	1930	New \	Inside City	l imits
	Aarylar 8a-f sl tified a	Director	MD Anne Arundel Oder						1 Yes 2	
	vith the N 23a or 29 st be no		10e. Street and Number 1190 Monie Road	10f. Zip Code 21113			. Citizen of What	Country?)	
980	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ed by Funeral	11. Marital Status 1 Never Married 2 Married 3 Wildowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 12. Yes 2 No If Yes, Give 1954-193 Year or Dates.	13. Was Decedent of Hispar If Yes, specify Cuban, M			14. Race - Al Black, W		,	
1215-0	thin 72 hou sne. than "natu ne Medical	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)	16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) Computer Analy	a most of working		b. Kind of Busine		1	
Baltimore, Maryland 21215-0036	l be filed wi fental Hygie rked other tic event, ti	To Be (17. Father's Name (First, Middle, Last) Barnett Margolis	18.	. Mother's Name (F Esther H		den Surname)			
, Mary	nd 2 should saith and N n 27 is ma er traumai			19b. Mailing Address (Street and I 17817 Overwood 1				Zip Code)	
more	Page 1 ar nent of He ant: If iter ury or oth		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place	ce of Disposition (Name of letery, crematory or other place) an Mem. Gardens	Dat 03/09	te 200 /12 Ol	c. Location - City .ney, Ma			
Balt	permit. Departi Import any inj		21. Signature of Funeral Service Licensee MISCY Nathura Juguson	22. Name and Address of	Facility Hine	s-Rinald	i Funeri	il Ho	ome, I	nc. 20904
	Ph. sician/ Medical Examiner		23a. Part 1. Enter the disease, or complications that caused the death. Described to the shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Parkinson's 1 Due to (or as a consequence)	Disease	uch as cardiac or re	espiratory arrest,		Inte	proximate erval Betwe set and Dea Years	en ath
	nted T	Examiner	Sequentially list conditions, if any, leading to immediate cause. Finer Underlying Cause (Disease or injury	ce of):						
00	tificate be executed ng physician and s as the burial-t	Medical Ex	that initiated events resulting in death) Last C. Due to (or as a consequence d	ce of):						
. Box 68760	To the Hospital or Attending Physician: The law requires that the death certifical within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending phy to the Funeral Director. After this certificate has been signed by the attending phy to the funeral director, page 2 should be detached for use as the completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director.	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal de 4 ☐ Pregnant at time of deat 9 ☐ Unknown	eath 3 Ectopic pregnancy			23d. Date of Month	delivery Day	Yea	ır
ds, P.O	uires that the signed by all be deta	by	Part II. Other significant conditions contributing to death but not resulting	ng in the underlying cause given ir	n Part I.		co use contribute			
Division of Vital Records,	The law rec cate has bee page 2 sho	Completed				24a. Was an autopsy performed 1 \(\sum \) Yes 2 \(\overline{D}\)	prior t death	to comple	findings ava etion of caus No	
/ital	sician: certific	o Be	25. Was case referred to medical examiner? 1 Yes 2 XNo Hospital: 1 Inpatient 2 FR	Othors	of Death (Check or		_V Assis	ted	Livin	g
on of √	nding Phy ath. :: After this e funeral c	icate: To	I Dilipatent 2 Dely	b. Time of 28c. Injury at injury work?	Nursing Home 28c 2 No	d. Describe how in		ecify)		
Division	tal or Atters after des al Director	al Certificate:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home building, etc. (Specify)	, farm, street, factory, office	281	f. Location (Street City or Town, St		Rural Rou	rte Number,	
	n 24 hou n 24 hou ne Funer	Medical	29a. Certifier (Check only one) 1	ge, death occurred at the time, dat id/or investigation, in my opinion, de knowledge, death occurred at the tir	te and place, and eath occurred at the me, date and place.	due to the cause(e time, date and pl , and due to the ca	s) and manner as ace, and due to th ause(s) and manne	stated. ne cause(s r as stated	s) and manne	er stated.
	Within Post	-	29b. Signature and title of certifier Ellott blook MD	29c. License num	nber	-	Date signed (Mo.			
			30. Name and aldress of person who completed cause of death (Item 23:	a) (Type, Print) adison Park Dr.,	. Glen Bi	vrnie. M	21061			
H	Stat		31. Date filed (Month, Day, Year) 32. Registrar's Signature	hald	,			-		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day}2012 Physician/ March 6, 6:00A Virginia L. Moxley Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 25815 Bowman Acres Lane Damascus Montgomery \$215-36-6516 If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Months Hours (Month. Dav. Year) 74 **Director** 1 □ M 2 🗓 F May 19, 1937 Maryland 28a-f show 10d. Inside City Limits items 23a or 28a-f sho ner must be notified at 10a. State 10b. County 10c. City. Town or Location Director 1 Yes 2 XNo Maryland| Montgomery Damascus 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 20872 U.S.A. 25815 Bowman Acres Lane within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 14 Race - American Indian. "natural", or iter dical Examiner Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 1 Never Married 2 X Married þ Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced Completed Il Hygiene. I other than "naturs vent, the Medical E 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 Nuclear College (1-4 or 5+) permit. Page 1 and 2 should be filed with.
Department of Health and Mental Hygiens Important: If item 27 is marked other the any injury or other tremans. Secretary Engineering Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 June Mason Edward Walter Funk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 25815 Bowman Acres Lane, Damascus, Maryland Bernard L. Moxley, Sr. - Husband Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Kaurial 2 Cremation 3 Removal from State 5 Other (Specify) 3/10/2012 4 Donation Montgomery Methodist Damascus, Maryland 22. Name and Address of Facility
Molesworth-Williams P.A., Funeral Home 21. Signature of Fundral Sen 26401 Ridge Road, Damascus, 20872 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Ph_sician/ My disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter oncerlying Due to (or as a consequence of) Examin burial-transi Cause (Disease or injury that initiated events resulting in death) Last that the death certificate be executed and Due to (or as a consequence of) nding physician ause as the burial Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No for Month Day Year Pregnant at time of death signed by the all P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed plnous 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has page 2 autopsy performed? I or Attending Physician: The after death.

Director: After this certificate I funeral director, 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 2 ី No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 2 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 1 🔀 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital 24 hours Medical X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier To the Hosp within 24 ho To the Fune completely f Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆 only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 11386 - HI March 7, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 06-2011

State

Genevieve A. Wroblewski

31. Date filed (Month

eoistrar's Signatur

Walter Reed National Military Medical Center, Rockville, Mc

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 2 Amend Item 10f per fh,g925,03/26/2012dhb Reg. No. 1 - For State Registrar 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death MARCh. Physician/ HATTIE 2:51 М McBroom Medical 4a. Facility Name (if not institution, give street and number of the street and street and street and street and street and street and street and street and street and street and street and street and street and street and street and street and street and street and street and street and street and street and street and street and street and street and street and street and street and street and street and street and street and street and street and street and street and street and street and street and street and street and street and street and street and street and street and street and street and street and street and street and street and street and street and street and street and street and street and street and street and street and street and street and street and street and street and street and street and street and street and street and street and street and street and street and street and street and street and street and street and street and street and street and street and street and street and street and street and street and street and street and street and street and street and street and street and street and street and street and street and street and street and street and street and street and street and street and street and street and street and street and street and street and street and street and street and street and street and street and street and street and street and street and street and street and street and street and street and street and street and street and street and street and street and street and street and street and street and street and street and street and street and street and street and street and street and street and street and street and street and street and street and street and street and street and street and street and street and street and street and street and street and street and street and street and street and street and street and street and street and street and street and street and street and street and street and street and street and street a 4b. City, Town, or Location of Death_ 4c. County of Death Examiner BALTIMURE If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) 4/11/1928 5. Social Security Number Age (In vrs. last birthday) **Funeral** Hours Country 222-16-7728 1 □ M 2 🏋 F Director 83 DELAWARE Usual Residence of Deceder 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10a. State notified at Director 1 Yes 2 XNo MD ANNE ARUNDEL LINTHICUM 10f. Zip Code 21090 10g. Citizen of What Country? 10e Street and Number ō must be Funeral 23a 21090 414M WEST MAPLE ROAD USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Examiner Armed Forces?

1 Yes 2 XNo Black, White, etc. ō þ 1 Never Married 2 Married permit. Page 1 and 2 should be filed within 72 hours after a Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examin Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: If Yes, Give Year or Dates Specify: WHITE 3 Nidowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) MANUGACT SEAMSTRESS 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ LESTER P. LAWSON EMMA LOFLAND 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13505 BENDER FARM RD., GREENWOOD, DE 19950 - Son DALE McBroom 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of I Important: If its any injury or of 1 X Burial 2 Cremation 3 Removal from State MILFORD, DE 4 Donation 5 Other (Specify) 3-19-2012 MILFORD COMM. CEM. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility BERRY-SHORT FUNERAL HOME 119 NW FRONT ST., MILFORD, DE 19963 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause at each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) (or as a consequence of Examiner Unkrom Sequentially list conditions, if any, leading to him equate cause. Enter Underlying Examine Cause (Disease or injury that initiated events resulting in death) Last use as the burial-trai Due to (or as a consequence of): nding physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Year Day Pregnant at time of death 5 Other (specify) ne BROOM. HATTIE 4 ☐ Pregnant a should be detached g Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 🗌 Yes 2 No 3 Probably 4 Inknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an funeral director, page 2 autopsy performed 1 🗌 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🗙 No ပ္ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 X DOA After this 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? 1 ☐ Yes 2 ☐ No Natural Accident injury 5 Pending Investigation e Funeral Director: A sletely filled in by the 1 in by the 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 only one) 29b. Signature ar title 29d. Date signed (Month, Day, Year) D0066588 dress of person who completed cause of death (Item 23a) (Type, Print) 200 CATON AVENUE BACTIMORE 21239 arpir Mees : YWO

DHMH 17 Rev 06-2011

State

Registrar

31. Date filed (Month, Day, Year)

26

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 4 Day Physician/ 2012 ELEANORE MORAN ARCH 10:21P SUE Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** g. Birthplace (State or Foreign Days 1 M 2 X F Hours Min. AUG. 20, Year) West Virginia Director 232-52-2006 77 Usual Residence of Decedent or 28a-f show 10a. State Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Maryland Frederick Frederick 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 1471 Key Parkway West/ Apt. 21702 United States 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. "natural", or 1 Never Married 2 Married Completed by If Yes. Give 1 ☐ Yes 2 🔀 No Specify: 3 Widowed 4 X Divorced Specify. White Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any injury or other traumatic event, the Mec Elementary/Seconday (0-12) College (1-4 or 5+) Product Demonstrator Retail Store Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Floyd Edgel1 Montgomery Alice Loma Riffle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael W. Moran / Son 7146 Boyers Mill Rd./New market, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Parklawn Cemetery March 10,12 Rockville Maryland 22. Name and Address of Facility Stauffer Funeral Home, P.A. 21. Signature of Funeral Service Licenses 1621 Opossumtown Pike/ Frederick, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line Interval Retween Immediate Cause (Final disease or condition Onset and Death Physician/ Ascular Medical resulting in death) **Examiner** DIRATOR Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of): The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last for use as the burial physician Physician/Medical 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 3 Ectopic pregnancy 5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 1 Yes 2 No 9 Unknown Month Day been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 Yes funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 Yes 2 No Other: ᅆ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural Accident injury 5 Pending 1 Yes 2 No М Investigation the 6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Box 68760 P.O. Records. Physician: of Vital To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After Division completed filled in by

Baltimore, Maryland 21215-0036

DHMH 17 Rev 7/2009

10

Registrar

Medical

29a. Certifier

only one

29b. Signature anattitle of cert

determined

enely

30. Name and address of person who completed cause of death, (Item 23a) (Type, Print)

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29d. Date signed (Month, Day, Year)

12-01909

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

James McNair	R	For State	Maryland / De	partment of Certificate of		and Mental H	Re	g. No. 201	2 0934
Physician Medical Examine		Decedent's Name (First, Middle,Last) James Franklin	Mcnair				2. Date of Death Month March 7, 2	Day Year	3. Time of Death 0245 hrs
	4	a. Facility Name (if not institution, give s Prince George's Hospital	reet and number)		4b. City, Towr Cheverly	n, or Location of Death		4c. County of Dea Prince Georg	
Funeral Director	,	Social Security Number 6. Sex	7. Age (In yr	rs. last birthday) 65 _{Yrs}	If Under 1 Months			6/1946 Fore	
nd show any cc.		sual Residence of Decedent Da. State 10b. County DC		city, Town or Locat ashingto					10d. Inside City Limits 1 Yes 2 No
death with the Maryland or items 23a or 28a-f show must be notified at once.		De Street and Number 544 48th Pl. N	<u> </u>		10f. Zip Coo 2001	9	10	lg. Citizen of What Co USA	untry?
77 6 1	by Funeral	Never Married 2 Married Widowed 4 Divorced If	Dates:	o If Y	es, specify C	f Hispanic Origin? (Suban, Mexican, Puerto No specify:	Rican, etc.)	White, etc. Specify: B1	
1036 Athin 72 hours no. Tr than "natur Medical Exam	шріетеа	15. Decedent's Education (Specify only Elementary/Secondary (0-12)	College (1-4 or 5+)	during m	ost of working	upation (Give kind of life, DO NOT use ret re Coord	inator		Moving Co.
MD 21215-0036 at 2 should be filed within 7 lith and Metal Hygiene. 27 is marked other than aumatic event, the Medical marked other than aumatic event, the Medical aumatic event.	8	7. Father's Name (First, Middle, Last) Alfred Pone				18.Mother's Name Mary	Mcnair ——		
MD 21 2 should the and Me (27 is ma umatic continuation)	2	9a. Informant's Name/Relationship (Type Mary Satterfield	d mother	19b. Mailing	Address (S 48th I	Street and Number or Pl. NE Wa	Rural Route Numl ashingt	ber, City or Town, Star On, DC 2	0019
Baltimore, lemit Pages land Department of Heal Important: If item injury or other tra		Da. Method of Disposition Burial 2 Cremation 3 Donation 5 Other Specify:	Removal from State	Ob. Place of Dispose crematory or off Fort L	incolr	n 3/	Date /16/12	20c. Location - City o	sburg, MD
	1	Signature of Funeral Service Licenses	1101300	2		ress of Facility Sons - 563			Washington DC 20019
Physician /Medicul Examiner	1						or respiratory arre	st, shock, of fleat	Between Onset and Death
		sequentially list conditions, b	e to (or as a consequenc						
		ause. Enter Underlying Cause	e to (or as a consequence to (or as a consequence						-
o, e be executed ysician and burial - transit	edical EX	d.	MENDED 23a, 27	per me,	3925 3-	-29-12 sm			
Box 68760, e death certificate be even the attending physician ed for use as the burial		b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of p 1 Live birth 4 Pregnant at time of	2 Fe	tal death her (Specify)	3 Ectopic pregn	ancy	23d. Date of delive Month	Day Year
i, P.O. Be ires that the de signed by the	2		9 Unknown	ot resulting in the u	underlying cau	se given in Part I.		bacco use contribute to	o the cause of death?
Records The law requirent to the law requirent to the law been page 2 should	Completed						24a. Was a autops perfori	sy prior to med? death?	
Vital bysician: this certifi	o ne	5. Was case referred to medical examiner? 1 ✓ Yes 2 No	pital: 1 Inpatient 2	✓ ER/Outpatient		Other Nursi	only one) ng Home 5 F	Residence 6 Oth	er:
ion of tending Pheath		7. Manner of Death 1 X Natural 5 Pending	28a. Date of Injury (Month, Day,Year)	28b, Time of I		Injury at Work? Yes 2 No	28d. Describe h	ow injury occurred	
Division ital or Attentors after death ral Director: lled in by the	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - A	At home, farm, stree	et, factory, offi	ce building, etc.	28f, Location (S or Town, St		Rural Route Number, City
Divis To the Hospital or At within 24 hours after of To the Funeral Director of the Puneral Director of To the Funeral Director of Total	g	9a. Certifier 1 Certifying Physician (Check only ne) 2 Medical Examiner: D	To the best of my known the basis of examination						
To vii	Med	9b. Signature and title of certifier	nd manner stated.			cense number		29d. Date signed (M March 7, 2012	onth, Day, Year)
20		Name and address of person who cor Ana Rubio MD. Assistant	npleted cause of death (I		imore Stre	et. Baltimore M	D 21223		
Sta Registr	te .	1. Data filed (Month, Day, Year)	32. Registrar 9 Sign						

ORIGINAL

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / Dep State of Maryland / Dep State of Maryland / Dep State of Maryland / Dep	eartment of Health ar Artificate of Death	•	0011	0001.2
			Registrar 1. Decedent's Name (First, Middle, Last)	Tillicate of Death	2. Date of De	Reg. No.	3. Time of Death
	Physicia Medic		Julia Sunorah McKinnon		Month March	Day Year 2012	3:07 P.M.
and the same	Examin		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of D	Death	4c. County of Dear	
1	_		Holy Cross Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Silver Spring If Under 1 Year If Under 24		Montgome	
	Funeral Director		578–28–4769 1 □ M 2 🔀 87 89 Yrs.		Min. (Month, Da	y, Year) Co	thplace (State or Foreign untry)
	d tow	L	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L.	Ocation	01/20/1	1923 ETIII	City, N.C.
	arylan ta-f sh ified a	Director	Md. Prince George's Laurel				1x Yes 2 No
	the M	Dir	10e. Street and Number	10f. Zip Code		10g. Citizen of What Co	ountry?
	h with	Funeral	14941 Cherrywood Drive	20707		U.S.A.	
	r deat or iten iiner r		Armed Forces?	Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, P	n? (Specify Yes or No- Puerto Rican, etc.)	14. Race - Ame Black, Whit	
036	rs afte ral", c Exarr	ed by	1	1 Tes 2 No Specify:		Specify:	rican- merican
2-0	2 hour	Completed	15. Decedent's Education 16a. Dece (Specify only highest grade completed) (Give	edent's Usual Occupation kind of work done during most of	f workina	16b. Kind of Business	
121	ithin 7 ene. • than he Me	Som	Elementary/Secondary (0-12) College (1-4 or 5+)	OO NOT use retired)			
d 2	iled w I Hygi other rent, t	Be	17. Father's Name (First, Middle, Last)	nager 18. Mother's	s Name (First, Middle,	LCosmetolog Maiden Surname)	y
ylar	ld be f Menta arked atic ev	욘	Joshua Deans	Julia	Arrington	1	
Mar	shou h and 7 is m rraum		1	ing Address (Street and Number of			
e,	and 2 Healt tem 2		20a. Method of Disposition 20b. Place of Disp	1 Cherrywood Dr	Date Date	20c. Location - City or	
E E	Page 1 lent of nt: If i		1 ☐xBurial 2 ☐ Cremation 3 ☐ Removal from State cemetery, cre 4 ☐ Donation 5 ☐ Other (Specify)	matory or other place)	/15/12	Suitland,	
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Liomsee	22. Name and Address of Facility Henry S. Wash:	ington (C		
ш	205 8 9		0 10 14 1. 0.00310	4925 Burroughs I	Ave.,N.E.,	Washington,	D.C. 20019
			23a. Part 1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line. Immediate Cause (Final	er the mode of dying, such as car	rdiac or respiratory an	rest,	Approximate Interval Between Onset and Death
	Physician/ Medical	ľ	disease or condition resulting in death) Severe Sesis Due to (or as a consequence of):				
	Examiner	l.	Programania				
	it d	nine	if any, leading to immediate Due to (or as a consequence of):				
	and and II-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last c. Respiratory Fail: Due to (or as a consequence of):	ure			
0	cate be executed physician and the burial-transit	edical	d.				
876	tificate ng phy as th		IF FEMALE:				
Box 68760	ith cert ttendii or use	ian/	23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 3			23d. Date of de Month	livery Day Year
B	requires that the death certific been signed by the attending I should be detached for use as	by Physician/M	1 Yes 2 No 4 Pregnant at time of death 5 9 Unknown	Other (specify)		Worth	Day Teal
P.0	that the ned by the detail	by Pi	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did to	obacco use contribute to	the cause of death?
ds,	equires een sig ould b	ted			1 🗆	Yes 2 No 3 P	robably 4 Unknown
CO	law re has be je 2 sh	Completed			24a. Was	prior to	topsy findings available completion of cause of
E E	sician: The law r certificate has b lirector, page 2 s		25. Was case referred to medical	00 Pt	1 🗌 Yes		s 2 🗆 No
Vita	ysicia s certi directe	To Be	examiner? 1 ☐ Yes 2 ☑ No Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatie	26. Place of Death (dence 6 Other (Spec	(6.)
of	ng Phy fter thi ineral		27. Manner of Death 1 ☑ Natural 5 ☐ Pending 1 ☑ Natural 5 ☐ Pending			ow injury occurred	
ion	ttendi death. tor: Ai the fu	Certificate:	2 Accident Investigation	M 1 \(\sumsymbol{\substack}\) Yes 2 \(\supsymbol{\substack}\) No	_		
Division of Vital Records, P.O.	l or At after a Direc		4 Homicide determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office	28f. Location (S City or Tow	Street and Number or Ru n, State)	ral Route Number,
	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death	occurred at the time, date and pla	ace, and due to the ca	ause(s) and manner as st	ated.
	the H hin 24 the Fu	Med	(Check 2 Medical Examiner: On the basis of examination and/or inve- only one) 3 Certifying Nurse Practitioner: To the best of my knowledge	e, death occurred at the time, date a	and place, and due to t	he cause(s) and manner a	s stated.
5	6 .≱6.8		29b. Signature and title of certifier	29c. License number D0055148		29d. Date signed (Monti March 06,2	
	. Gr		30. Name and address of person who completed cause of death (Item 23a) (Type,				J . 2
	f So		Delroy Anglin, M.D. 1500 Forest	Glen Road, Silv	ver Spring	Maryland 2	0910
	Stat Registra		31. Date filed (Month, Day, Year) 32. Registrar's signature				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death . Decedent's Name (First, Middle, Last) 3. Time of Death Month 3 $20\overset{\text{Year}}{12}$ Physician/ 2:00 P M Lina Nogin Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Hebrew Home Of Greater Washington Rockville 9. Birthplace (State or Foreign Country)
Ukraine 8. Date of Birth 7. Age (In vrs. last birthday) Social Security Number Funeral (Month, Day, Year) -30-1940 1 □ M 2 🛛 F Months Days Hours 212-35-8812 **Director** Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County within 72 hours after death with the Maryland Director 1 X Yes 2 No MD Montgomery Derwood 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral United States 20855 16105 Crabbs Branch Way #34 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates. 14 Race - American Indian 11. Marital Status Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Civil Engineer Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 1 and 2 should be fill of Health and Mental item 27 is marked Chaya Pinhusovna Denenberg Pesach Yankelevich Spitkovskiy 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20855 19a. Informant's Name/Relationship (Type, Print) 16105 Crabbs Branch Way, #34, Derwood Maryland Yuliy Nogin - Husband other f 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1 🛣 Burial 2 🗌 Cremation 3 🗋 Removal from State 3-7-2012 Olney, Maryland Judean Mem. Gardens 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Edward Sagel Funeral Direction Kurt Blake 1091 Rockville Pike, Rockville, Maryland 20852 M01477 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Pnysician Metastatic Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to for as a consequence on Exami that the death certificate be executed Cause (Disease or linjury anding physician and use as the burial series that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 5 Other (specify) Pregnant at time of death ed by the a Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ should be 2 No 3 Probably 4 Unknown The law requires Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy perform 1 🗌 Yes or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: Other: 200 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA ၉ Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred Certificate: injury work? 1 ☐ Yes 2 ☐ No Natural 5 Pending Investigation Accident Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Hospital Medical Sertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier D69568 ddress of person who completed cause of death (Item 23a) (Type, Print) 6121 Montrose Road Pockville A. Chilakamar MD

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death State Registrar 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) March 8, 2012 3:56 Α Physician/ Tauchious J. Owens Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Prince George's **Examiner** Hyattsville St. Thomas More Rehabilitation Ctr. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day,) June 23, If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Year) 911 5. Social Security Number South Carolina Min. Hours Funeral Days 1 M 2 □ F 100 065-14-6345 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 28a-f show 10b. County er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a. State 1 🖾 Yes 2 🗆 No Director Washington DC 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 20018 Funeral 3204 Central Avenue NE Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian permit. Page 1 and 2 should be filed within 72 hours after death \(\)
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or itemany injury or other trainmatics. 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. African 1 Never Married 2 Married Specify: þ 1 Yes 2 No Specify Baltimore, Maryland 21215-0036 If Yes, Give American 3 - Widowed 4 - Divorced Year or Dates Completed 16b, Kind of Business Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Self-Employed Elementary/Seconday (0-12) 12th College (1-4 or 5+) Carpenter 18. Mother's Name (First, Middle, Maiden Surname) Be 17. Father's Name (First, Middle, Last) Frances A. Pogue Jesse Baker Owens ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 20018 Washington, DC 3204 Central Avenue NE <u> Viola Owens - Wife</u> 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition March Brentwood, Maryland 1 A Burial 2 Cremation 3 Removal from State 2012 Ft. Lincoln 4 Donation 5 Other (Specify) 22. Name and Address of Facility Stewart Funeral Home, Signature of Funeral Service Licepses Washington, DC MOO560 4001 Benning Road NE 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Due to (or as a consequence of): Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical or Attending Physician: The law requires that the death certificate be Box 68760 23d Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) Year Month Day in the past 12 months? Pregnant at time of death 2 No 9 Unknown detached 9 Unknown P.O. 23e. Did tobacco use contribute to the cause of death? Qther significant conditions contributing to death but not resulting in the underlying cause given in Part I. within 24 hours after death.

To the Funeral Director: After this certificate has been signed completed filled in by the funeral director, page 2 should be de 1 Yes 2 No 3 Probably 4 Unknown by Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an 108/10to autopsy performed? Yes 2 No 26. Place of Death (Check only one) 25. Was case referred to medical Be Other: examiner? Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 2 No 1 Yes ၉ 28d. Describe how injury occurred 28c. Injury_at 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death Certificate: injury work? 5 Pending 1 Yes 2 No Natural Investigation 2 Accident
3 Suicide 28f. Location (Street and Number or Rural Route Number, 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be City or Town, State) determined Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. the Hospital of Medical 29a. Certifier (Check

State Registrar only one)

29b. Signature and title of certifier

Paul Devore 31. Date filed (Month, Day, Year) 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6510 Kenilworth Ave. Suite 1400 Hyattsville, Md. 32. Registrar's Signature

29c. License number

00063681

29d. Date signed (Month, Day, Year)

200

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20784

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ March 2012 Katherine Kyung Ai Pang 11:43 pM Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Washington Adventist Hospital Takoma Park Montgomery If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex Birthpia Country) K<u>orea</u> **Funeral** Days 1170271945 1 M 2 X F 213-76-7749 66 Yrs Director Usual Residence of Decedent ?7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10b. County with the Maryland Director 1 Yes 2 No MD Montaomeru Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8009 Park Crest Drive 20910 U.S.A. within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status 12. Was Decedent Ever in U.S Armed Forces?
1 ☐ Yes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 Married ģ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Asian-American 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 15 Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene.
is marked other than College (1-4 or 5+) Elementary/Seconday (0-12) Artist Art Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Unknown Kim Soon Ai Yang permit. Page 1 and 2 should I Department of Health and Me Important: If item 27 is mark 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 8009 Park Crest Drive, Silver Spring, MD 20910 Charles Eun Ho Pang- Spouse injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2X☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Lincoln Crematory 03/13/2012 Brentwood, Maryland 22. Name and Address of Facility Hines-Rinaldi Funeral Home Inc. 21. Signature of Funeral Service Licensee any 11800 New Hampshire Ave., Silver Spring, MD 2090# 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Approximate death. Do not enter the milde of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a co Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a quence of) Examir To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-taces. Due to (or as a cons resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregna
☐ Other (specify) Live Birth 2 - Fetal death 3 Ectopic pregnancy in the past 12 months? Day Month Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy performed? 1 Yes 2 No Yes 2 No 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Other: 2 🗹 No ည 1 🗹 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and tle of certifier 29c. License number 29d. Date signed (Month 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7701 Carroll Ave.. Takoma Park. MD 20912 <u>Nasreen Kango M.D</u>

State Registrar 31. Date filed (Month, Day, Year) MAR 1 2 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 9:40 P_{M} Holly Sylvia Palmer March 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Frederick **Examiner** Frederick Frederick Memorial Hospital Age (In yrs. last birthday) 6. Sex If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🔣 Months Days Hours March **Director** 217-56-0884 53 Tenn. Usual Residence of Decedent show with the Maryland "natural", or items 23a or 28a-f sho 10a. State 10c. City. Town or Location 10d. Inside City Limits Director 1 A Yes 2 No Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1308 West 7th Street 21702 U.S.A. within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify. Specify: 3 Widowed 4 Divorced Completed Year or Dates White the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) filed within 72 tal Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Child & Adult Care <u>Administrative Assistant</u> Be 17. Father's Name (First, Middle, Last) permit, Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 Is marked ott any injury or other traumatic even any injury or other traumatic even 18. Mother's Name (First, Middle, Maiden Surname) John William Hale Elizabeth Knowles 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elizabeth Hale / Mother 1308 West 7th Street, Frederick, Maryland 21702 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State \square Burial 2 \square Cremation 3 \square Removal from State Smithsburg Crematory 3/7/2012 4 Donation 5 Other (Specify) Smithsburg, Maryland Signature of Funeral Service Licens 22. Name and Address of Facility Robert E. Dailey & Son F.H., P.A. 1201 North Market Street, Frederick, MD., 21701 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Immediate Cause (Final Onset and Death Physician/ ATHENO SCLEROSIS ORONMY ARTERY DISEASE Medical resulting in death) Due to (or as a consequence of) Examiner BREASTCA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence oi). Exam Hospital or Attending Physician; The law requires that the death certificate be executed for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Pregnant at time of death 5 Other (specify) 2 No ed by the a detached f 1 ☐ Yes 2 L 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available 24a. Was an autopsy certificate has prior to completion of cause of death? 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Hospital: 1 🗌 Yes 2 💢 No 1 Anpatient 2 ER/Outpatient 3 DOA မ 4 Nursing Home 5 Residence 6 Other (Specify) After this o 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred work? 1 Natural 2 Accident injury 5 Pending 2 🗌 No Investigation 24 hours after death Funeral Director: A completed filled in by the 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined City or Town, State Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basic of examination and/or investigation is not active. Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) -05-2012 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) Ave. FREDERICK

DHMH 17 Rev 7/2009

Registrar

SIBTE

31. Date filed (Month, Day, Year)

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32. Registrar's Signature

HOUSE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend 8,20a-b, per fh, 9925, 3-29-12 sm
State of Maryland 7 Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Dav Year PERKINS 7, 41 PM **Physician** EILEEN 17ARCH-10-2012 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner GRACE HAVRE 15 HARPORD MEMORIAL HOSOITAL HARFORD If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 1947 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months 1 □ M 2 🛛 F 65 11/27/1945 Connecticut Director 265-90-6545 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Paulical Eventure in ust be multified at 1 TYes 2 □ No Director Harford Havre de Grace MD 10g, Citizen of What Country? 10f, Zip Code 10e. Street and Number U.S.A. 205 Whirlaway Lane 21078 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☐**X**No 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 🛣 No Specify: If Yes, Give Year or Dates: Specify: White ģ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Customer Service Service 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Maryland Be n and Mental F should be Evelyn Boulard Julian Andia 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Health a 205 Whirlaway Ln., Havre de Grace, MD 21078 Ray Perkins (Husband) Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages 1 Department of H Important: If itel any injury or otl 1 Burial 2 ☐ Cremation 3 View Cemetery3/16/2012 4 ☐ Donation 5 ☐ Other (Specify) Middletown, NJ Signature of Funeral Service Licensee 22. Name and Address of Facility John F. Pfleger Funeral Home 15 Tindall Rd., Middletown, NJ 07748 Tart1. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only the second each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) HE MOREHASIC CHOCK **Physician** /Medical Due to (or as a consequence of): Examiner GSOPHASEAL ILGGAIN! if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner CIRRHOSIN Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ☒ No 3 Ectopic pregnancy Month Day Year for 5 Other (specify) Ö 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by THROTTROCTTO PENIA 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown CAN CEN 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No CHONO THOMPY 24a Was an autopsy performed? 1 □ Yes 2 □ No HYTER TONIION Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🖼 Ño 1 N Inpatient 2 N ER/Outpatient 3 N DOA Division of 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: Hospital or Attending 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) n 24 hours after d e Funeral Direct 4 - Homicide 1 **Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ** Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier, 21338 MARCH. 11. 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AUN SWEATHAN GANRE de GRACE HARFORD presente Hospiate Registrar's Signatur 31. Date filed (Month, Day Year) MAR 1 5 2012 State Registrar

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

		Please amend in State Amend#23bg - State Amend#23bg Registrar 1. Decedent's Name (First, Middle, La		ICÍAn	3 / 1' 3 Cei	dificate of	Death		2. Date of Dea		No.	14	0 9 3 4 8
Physicia Medic		Stanley E		ties					$\mathtt{March}^{\mathtt{Month}}$	1,	^D 2012	Year	16:39 P M
Examin	_	4a. Facility Name (if not institution, given Southern Marylan				4b. City, Town,	or Location of E				4c. County P rin		eorge's
Funeral		5//-/4-4186		Age (In yrs. Ia	ast birthday)	If Under 1 Yea Months Days		Hrs. Vin.	8. Date of Birt (Month, Day		r)	9. Birth Cour	place (State or Foreign
Director		Usual Residence of Decedent	1 🔀 M 2 🗆 F	56	Yrs.				Aug. 21	ι,	1955_	D	С
rand f shov d at	tor	10a. State 10b. County		10c. Cit	y, Town or Lo	cation							10d. Inside City Limits
28a-1	Director	Maryland Prince C	George's				ple Hil	.1s					1 ☒ Yes 2 ☐ No
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ems c	Funeral	6303 George Wash	12. Was Deceder	nt Ever in U.S	3. 13. \	Was Decedent of	Hispanic Origin	? (Spec	cify Yes or No-	Un	ited		es can Indian,
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Inportment of Health and Mental Hygiene. Hygiene are strong the manual from 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	Armed Forces 1 Yes 2 If Yes, Give Year or Dates			If Yes, specify Cu 1 ☐ Yes 2 🛛 N	ban, Mexican, P	uerto F	Ričan, etc.)		Bla	ck, White, Bla	etc.
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Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

		Plea	ase Type or Pr State of N					e All Copie d Mental Hy		Legible.		
	•	State Registrar 1. Decedent's Name (First, Middle	l ast)		Cen	rificate of L	Death	2. Date of De	Reg. No.	2012	3. Time of	345
Physicia Medic		Anthony Panch	ik					Month March		012 Year	4:40	Рм
Examin	er	4a. Facility Name (if not institution 5806 Chillumga				4b. City, Town, or Ch	Location of De	eath		County of Death Prince (George'	s
Funeral Director		5. Social Security Number 182-14-6573	6. Sex 7. A	ge (In yrs. las	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 H Hours M	in. (Month, D	ay, Year)	Coun		
nd thow at	or	Usual Residence of Decedent 10a. State 10b. County			, Town or Loc	ation		April	17, 19		City,	
Maryla 28a-f s notified	Director		e George's	Chi	11um						1 🛚 Yes	2 🗆 No
with the s 23a or ust be	Funeral [10e. Street and Number 5806 Chillumga	ate Road			10f. Zip Code 20	782		10g. Citiz	ten of What Cour	try?	
permit. Page 1 and 2 should be filed within 72 hours after death with the Manyland Department of Health and Mental Hygiene. Important: If time Z7 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	11. Marital Status 1 ☐ Never Married 2 🛣 Mar 3 ☐ Widowed 4 ☐ Divorced	If You Give	0	V I	/as Decedent of H Yes, specify Cuba ☐ Yes 2 🖾 No		(Specify Yes or No erto Rican, etc.)		4. Race - Americ Black, White, of Specify: White	etc.	
72 hour In "natu Medical	Completed	(Specify only highe	nt's Education est grade completed)		(Give k	ent's Usual Occup ind of work done of NOT use retired)	ation during most of v	vorking		d of Business/Ind		
d within lygiene. ther than the lut, the l	Be Cor	Elementary/Secondary (0-12) 12	College (1-4 or	5+)		refighte				Firefigh	iter ———	
d be file Mental H arked of	To B	17. Father's Name (First, Middle, I John Panchik	_ast)					Name (First, Middle Evanicky	, Maiden Si	umame)		
12 shoul alth and 1 27 is m		19a. Informant's Name/Relations Dorothy E. Pa:		e				Rural Route Numb			Code)	
ge 1 and nt of Hea : If item or othe		20a. Method of Disposition 1 X Burial 2 Cremation	3 Removal from State	te ce	emetery, crem	ition (Name of atory or other plac		Date	1	cation - City or To		
permit. Pa Departmer Important any injury once.		4 Donation 5 Other (S		Fo	22.	oln Cemete	ss of Facility	14/2012	473	ntwood, 9 Baltin	ore Av	<i>r</i> enue
	_	23a. Part 1. Enter the disease, or	complications that caus	ed the death				lome, P.A		ttsville 	Approximate	
Physician/		shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)	only one cause on each li	/ /	encu	atic/	ance			\$	Interval Bety	
Medical Examiner	_	Sequentially list conditions,	Due to (or a	s a conseque	ence of):							
ited d ansit	xaminer	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		s a conseque	ence of):							
cate be executed physician and s the burial-transit	ш	that initiated events resulting in death) Last	Due to (or a	s a conseque	ence of):		•	-				
tificate b	Medic	IF FEMALE:	d									
To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. with 124 hours after death. completely filled in by the funeral director, page 2 should be detached for use as the	Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcom 1 Live Birth 4 Pregnant 9 Unknowr	2 Fetal at time of de	death 3 🗌	Ectopic pregnand Other (specify)	≽y		2	3d. Date of delive Month	,	/ear
quires that t en signed b ould be deta	by	Part II. Other significant condition	ons contributing to death	but not resu	ulting in the ur	nderlying cause giv	ven in Part I.			e contribute to th		4
: The law re icate has be r, page 2 sh	Completed							per 1 🗌 Yes	opsy formed?	24b. Were auto prior to co death? 1 Yes	mpletion of c	
hysiciar his certif il directo	To Be	25. Was case referred to medical examiner? 1 Yes 2 No			ER/Outpatien	Oth	ace of Death (C er: 4 Nursin	g Home 5 Res	idence 6	Other (Specify)	
nding P ath. :: After ti e funera	cate:	27. Manner of Death 1 Natural 5 ☐ Pendir 2 ☐ Accident Investi			28b. Time of injury	28c. Injur work M 1 🗆		28d. Describe	how injury	occurred		
al or Atter after des Director d in by th	Certificate:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	ined 28e. Place of I	njury - At hor etc. (Specify)		et, factory, office			(Street and wn, State)	Number or Rural	Route Numb	er,
e Hospitz 24 hours e Funeral	Medical	(Check 2 Medical I	g Physician: To the best Examiner: On the basis of g Nurse Practitioner: To	examination	and/or investi	gation, in my opinio	on, death occurr	ed at the time, date	and place,	and due to the ca	use(s) and ma	nner state
vithi vithi com		29b. Signature and title of certifie	Hayo			29c Licenson	e number 13375	-	29d. Date	ligned (Mghth, 1	Day, Year)	
180			who completed cause of WEMLITTUM	death (Item	23a) (Type, p	WATION	BUD	SOITEN	-RG	TEN (SULNET,	41) 21	06/
Stat Registra		31. Date filed (Month, Day, Year) NAR 1 2 2012	32. Regis	trar's Signati	ure							

State Registrar DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		_	For State	State of	Marylan			nt of H <i>te of D</i>		d Mental H		00	L 0	00000
			Registrar 1. Decedent's Name (First, Middle	, Last)		Cer	unca	le oi D	eauri	2. Date of I	Reg. No. Death	20	16	3. Time of Death
	Physicia Medic		Elizabeth D. ((ueen						March	6, 20	012	Year	10:57 Am
	Examin	_	4a. Facility Name (if not institution, Suburban Hosp		er)			, Town, or ethes	Location of De	eath		County o		7
	Funeral		5. Social Security Number 503-03-8624		Age (In yrs. la	ast birthday)	If Und Months	er 1 Year Days	If Under 24 I Hours N		Bi rt h Da <i>y</i> , Yea <i>r)</i>		9. Birthp Count	lace (State or Foreign ry)
	Director		Usual Residence of Decedent	1 □ M 2 🛂 F	96	Yrs.				02/05	/1916	S	outh	Dakota
	yland f shov ed at	tor	10a. State 10b. County			y, Town or Loc							10	Od. Inside City Limits
	e Man r 28a- notifie	Director	MD Montgo	omery	Ro	ckvi11		ip Code			10a Cit	izen of WI	ant Count	1 X Yes 2 □ No
	with the s 23a o	Funeral	7007 Old Cabin	Lane			101.2	2085	2		_	ted S		
036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		11. Marital Status1 ☐ Never Married 2 ☐ Marriage3 ☐ Widowed 4 ☐ Divorced	12. Was Decede Armed Force 1 Yes 2 If Yes, Give Year or Date	No No	l II	f Yes, sp	ecify Cubar	spanic Origin? n, Mexican, Pu Specify:	(Specify Yes or N lerto Rican, etc.)		14. Race Black Specify: √	, White, e	etc.
Baltimore, Maryland 21215-0036	thin 72 hour ne. than "natur ne Medical	Completed by		t's Education st grade completed) College (1-4			kind of w O NOT u	ork done di se retired)	tion uring most of	working		ind of Bus	siness/Inc	dustry
and 2	oe filed wit intal Hygie ced other cevent, the	To Be (17. Father's Name (First, Middle, L Eugene M. Don1:	·		110mer	iare			Name (First, Midd.	le, Maiden S	Surname)	aefer	
Mary	d 2 should be filed valth and Mental Hyg 27 is marked othe rtraumatic event,		19a. Informant's Name/Relationsl Michael Queen	nip (Type, Print)						Rural Route Num				Code)
nore,	age 1 and and of Healing 1: If item 2		20a. Method of Disposition 1 X Burial 2 Cremation	3 Removal from St	C	Place of Dispo	sition (Na	ame of other place	e)	Date 4-27-201	20c. Lc	ocation - 0	City or To	
Baltin	permit. Pa Departme Importan any injury once.		4 ☐ Donation 5 ☐ Other (S			22	. Name a	and Address	s of Facility	oseph Gav	wler's	s Sor	ns In	nc.
		Н	23a. Part 1. Enter the disease, or shock, or heart failure. List of	complications that cau	used the deat							grom	, DC	Approximate Interval Between
	h, i i Medical		Immediate Cause (Final disease or condition resulting in death)	_ Intra		1 Hemo:	rrha	ge No	n-trau	matic			_	Onset and Death
E.	Examiner	Ĺ	Sequentially list conditions,	b.	as a consequ	dence oi):								
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	cate be executed physician and sthe burial-transit	al Ex	that initiated events resulting in death) Last	Due to (or	as a consequ	uence of):								
760	cate b physics the b	ledical		d										
Box 687	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the allending physician and for the Funeral Director: After this certificate has been signed by the allending physician and for property filed in by the funeral director, page 2 should be detached for use as the burial-transity.		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2▼ No 9 □ Unknown		rth 2 ☐ Feta nt at time of d	al death 3 🗌	Ectopio		ý		-	23d. Date Mon		ery Day Year
P.O.	es that the dear igned by the at i be detached f	y Ph	Part II. Other significant condition	ons contributing to dea	th but not res	sulting in the u	ınderlyin	g cause giv	en in Part I.	23e. Die	d tobacco u	ise contril	oute to th	e cause of death?
ds,	requires been sign should be	ted b								_ 1	Yes 2	X No :	3 🗌 Prob	oably 4 🗌 Unknown
Division of Vital Records,	sician: The law rer certificate has be lirector, page 2 sh	Completed								pe 1 □ Ye	as an topsy rformed? ss 2 🛣 No	pr de	ere autor for to cor eath?	osy findings available mpletion of cause of
ital	sician certifi lirecto) Be	25. Was case referred to medical examiner? 1 √√√√√√√√√√√√√√√√√√√√√√√√√√√√√√√√√√√√	Hospital:		ER/Outpatier		Othe	r.	Check only one)	nidonos 6	- Othor	(Cnocify	1
of \	ng Phy fter this ineral d	ate: To	27. Manner of Death 1 XNatural 5 ☐ Pendii	28a. Date of		28b. Time of injury		28c. Injury work	at ?	28d. Describ				. <u> </u>
ivision	To the Hospital or Attending Physician: The la within 4 hours after death. To the Funeral Director. After this certificate ha To the Funeral Director. After this certificate has the properties of the funeral director, page	Certificate:	2 Accident Investi 3 Suicide 6 Could 4 Homicide determ	gation not be 28e. Place of	f Injury - At ho , etc. <i>(Specif</i> y	ome, farm, str	M eet, facto		Yes 2 No	28f. Location	(Street and Town, State)		or Rural	Route Number,
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	the H thin 24 the F mplete	Me	only one) 3 Certifying	Nurse Practitioner:	o the best of r	ny knowledge	, death o	ocurred at the	ne time, date a	nd place, and due	to the cause	e(s) and mate signed	anner as s	stated.
_	^{2 3} ² /5		29b. Signature and title of certifie	Alt.				90. License			29d. Da		201)
	,		30. Name and address of person Anitha Chetty	who completed cause MD 8600 0	of death (Item	1 23a) (Type, F	rint) n Ro			, MD 208		101		
	Sta Registr		31. Date filed (Month, Day, Year)	37. Reg	istrar's Signa		No.							

		For State		State	of Mary				it of H e of D		and M	lental Hy		20	12	0935	
		Registrar 1. Decedent's Nam					Certi	ilicati	3 OI L	Calli		2. Date of De				3. Time of Death	_
Physiciar Medica	al		L. Reigle									March ^{Month} 12			Year	14:25 P	1
Examine	er	4a. Facility Name <i>(if</i>		, give street and nu al Hospital	mber)		1			Location o				c. County o Calvert			
Funeral		5. Social Security N	umber	6. Sex 1 🙀 M 2 🗆 F	7. Age (In)	yrs. last birtho	- 1	If Unde Months	1 Year Days	If Under :	24 Hrs. Min.	8. Date of Bir	th (27)© er)	Ţ	9. Birthp	lace (State or Foreig	m
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s 23a nust be	Funeral Director	4717 Rock	Creek C	ircle				206						ted Sta			
, or	ρ	11. Marital Status1 Never Marr3 Widowed		12. Was Dec Armed F ried 1 \(\frac{1}{2}\) Yes If Yes, Gi Year or D	orces? 2 No 6 ve	n U.S. 5–70	If Y	es, spec	ify Cubar	spanic Orig n, Mexican Specify:	gin? (Spe , Puerto I	cify Yes or No- Rican, etc.)		14. Race Black Specify: V	White, e		
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und 2 shou lealth and im 27 is m her traum		19a. Informant's Na Frances C.		nip (Type Print) — wife						nd Number Circle	r or Rura St. I	eonard,					
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permit Depar Impor any in		21. Signature of Fui	neral Service I	Licensee			22.1 44 0	Name ar 5 Bro	d Addres XXMES	s of Facility Is. Rd	Rausc I. Por	h Funera t Republ	1 Ha ic M	me D 20676	ó		
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p ji	Examiner	Sequentially list co if any, leading to in cause. Enter Under	nditions, nmediate rlying	b. Posto	(or as a con	sequence of		UV				W - CE					_
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te be e nysiciar ne buris	edical			d	<u>'</u>												
ertifical ding ph		IF FEMALE:		23c. If yes, ou	itcome of pre	egnancy											_
To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending is completed filled in by the funeral director, page 2 should be detached for use as	Physician/M	23b. Was decedent in the past 12 1 Yes 2 9 Unknown	months?	1 🔲 Live	e Birth 2 🗔 gnant at time	Fetal death		Ectopic Other (sp		у	-			23d. Date Mont		ry Day Year	
uires that in signed k	ا ھ	Part II. Other signif	icant condition	ons contributing to	death but no	t resulting in	the unc	derlying	cause give	en in Part I.				use contrib		e cause of death? ably 4 Unknow	'n
sician: The law req certificate has bee lirector, page 2 sho	Completed											24a. Was autor perfo	osy rmed?	pri de		sy findings available	,
ertifical	8 B	25. Was case referre		// Complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of the complete of						ace of Deat	h (C <i>heck</i>	1 \(\superset \text{Yes}\)	2 1997	NO 11	Yes ?	2 L 190	
Physic this corral dire	잍	1 Yes 2 2 27. Manner of Death	3 No 1	Hospital:		2 ER/Outp			Othe 8c. Injury	4 ∟ Nu		ne 5 Resid					_
nding ath. r: After e fune	icate	1 Natural 2 Accident	5 Pendir	ig (Mor	nth, Day, Yea		ury	M	work?			.8d. Describe h	iow inju	ry occurred			
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completed filled in by the funeral director,	al Certificate:	3 Suicide 4 Homicide	6 ∐ Could determ	ined 28e. Place	e of Injury - A ling, etc. (Sp	At home, farn ecify)	n, street	t, factory	, office		2	28f. Location (S City or Tow			or Rural I	Route Number,	
Hospi 24 hou Funer eted fill	Medical	(Check 2	Medical E	Physician: To the examiner: On the ba Nurse Practioner:	isis of examin	nation and/or i	investig	ation, in	ny opinio	n, death oc	curred at	the time, date a	nd plac	e, and due t	o the cau	se(s) and manner sta	tec
To the within To the compl	2	1.7.1	title of certifier		MD	or my knowled	age, de		License		213			ate signed (•	_
RW 14+1		30, Name and addre	ess of person	the completed cau	se of death	(Item 23a) (Ty	pe Prir		ita	IB	000	d Prir	nce	Treo	eric	KIND KIND	7
State Registra	-	31. Date filed (Mont)	h, Day, Year)	1 4 2012	Registral's Si	ignature	g.	ba	Kas								

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			1- For State Registrar				Certif	ficate o	of Death			F	Reg. No.	2 U	16	0935
	Physicia		1. Decedent's Name ((First, Middl	le,Last)							Date of Dea	ath			3. Time of Death
Vle	dical Exami				aldin	e Luci	lle Ro	obers	on			Month March 12	Day 2012	Year		2043 hrs
			4a. Facility Name (if n	not institutio	n give stre				4b. City, Town, o	or Location o		1011		. County of	Death	
			1000 Brightse		_	,			Hyattsville				F	Prince Ge	eorge	's
		-	5. Social Security Nur		6. Se x	Ι 7 Δα	e (In yrs. last	hirthday)	If Under 1 Ye	ar If Unde	r 24Hrs. 8	Date of B	irth/MM/	מאייאין מיי	9. Birtl	nplace (State or
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	Director		370-00-40	370	1 M	2 X F	66	Y	rs.	1.11		May 6), I	945	Cou	D. C.
		[Usual Residence of D													10d. Inside City Limits
	v any		10a. State	0b. County			10c. City, To								- 1	1 X Yes 2 No
	and show	5	Maryland	Princ	ce Ge	orges	Laı	ndove	r							- 17
	faryl	Director	10e. Street and Numb						10f. Zip Code				-	zen of Wha		•
	more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28s-f sho or other traumatic event, the Medical Examiner must be notified at once.		1000 Brig	ghtsea	at Ro	ad; Apt	. 123		207	85			Uni	ted S	tat	es
	with with 18 23	<u>10</u>	11. Marital Status		12.	. Was Decedent			Vas Decedent of H				0-			an Indian, Black,
	eath item	Funer	1 X Never Married	2 M	arried	Armed Forces? Yes 2	X No	lf lf	Yes, specify Cuba	an, Mexican,	Puerto Rio	an, etc.)		White,	etc.	
	fler d		3 Widowed	4 Div	orced If Ye	es, Give Year	110	1	Yes 2 📉 N	lo specify:				Specify:	В	1ack
	urs a	à.	15. Decedent's Educ	cation (Spe		Dates: ighest grade con	npleted) 16		ent's Usual Occup				16b. i	Kind of Busi	iness/Ir	ndustry
	2 ho	ğ.	Elementary/Second	dary (0-12)		College (1-4 or	5+)	during	most of working lif	fe. DO NOT	use retired)				
	bin 7	Completed	11th grad	de					Homemak	cer				Don	est	ic
	5-0C led wit Hygien other	팃	17. Father's Name (F	irst, Middle,	, Last)	~				18.Mother	s Name (Fi	rst, Middle,	Maiden	Surname)		
	a file a H code	Be	Leon V	Verna	rd R	oberson				Go1	die	Marga	ret	Hens	on	
	21215-0036 uld be filed within 7 Mental Hygiene. marked other than	2	19a. Informant's Nam				ter)	19b. Maili	ng Address (Stre							Zip Code) 20744
	and 2 shoule lealth and 1 tem 27 is retraumatic		Christine			•	CC_ /									
	Baltimore, MI permit. Pages 1 and 2 s Department of Health at Important: If item 27 injury or other traum.	1	20a. Method of Dispo		avetn	RODELS	20b. Plac	ce of Disp	osition (Name of c	emetery,		ate		Location - (
	10re ages 1 a nt of H.	- {	1 X Burial 2	Cremation	n 3 🔲 F	Removal from St	ate crer	matory or	other place)			1 22,2	2012			
	Baltimore, permit. Pages I an Department of Hee Important: If ite injury or other tr		4 Donation, 5	Other S	pecify:		Heri	_	Memoria						_	ryland
	Balt permit. Departr Import injury		21 Signeture of Fune	eral Service	Licensee	1/								_	_	Morticians,
	E E A B CO		dow	IU.	An	116	CC0333									on,D.C.2001
	Physician		23a. Part I. Enter the failure. List only				the death. Do	o not enter	the mode of dying	g, such as ca	ardiac or re	spiratory ar	rest, sho	ock, or hear	t	Approximate Interval Between Onset and
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		_	Sequentially list cond	ditions.	b											
		ē	if any, leading to imm cause. Enter Underly	nediate		to (or as a cons	equence of):									
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	cords, P.O. Box 68760, The death certificate be executed that been signed by the attending physician and 2 should be detached for use as the burial - transit	평	X UNPENDED		<u>ار آ</u> ر	JENIDED 23a	.pt.TT	. 27 . r	er me,g	926 4-	23-12	sm				
	D, be es	ğ											-			
	76(Physician/Medi	IF FEMALE: 23b. Was decedent pr	regnant in th		3c. If yes, outcor	ne of pregnar	· .		Ectopic	: pregnancy		23	 d. Date of d Month 		ay Year
	68 certif	ä	past 12 months?		4	⊟ B	time of death	=	otal additi	Lctopic	, pregnancy		- 6	WORL		ay rea
	OX eath for u	i <u>s</u>	1 Yes 2 ✔ No	9 🔲 Uni	known 9			٠ ـ ـ ـ ـ ـ ـ ـ ـ ـ ـ ـ ـ ـ ـ ـ ـ ـ ـ ـ	Other (Specify)							
	the d	된	Part II. Other signific	cant condit	tions con	tributing to deat	h but not resu	Ilting in the	underlying cause	given in Pa	rt I.	23e. Did	tobacco	use contrib	ute to t	he cause of death?
	P.C.	ģ	Diabetes					-				1 Ye	es 2 🔻	No 3	Proba	ably 4 Unknown
	S, luires	ed	Diabetes				_					24a. Was	an	24h W	ere aut	opsy findings available
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	Vital Rec ysician: The l his certificate l director, page	Be	examiner? 1 ✓ Yes 2	No	Hosp	ital: 1 Inpatie	ent 2 EF	R/Outpatie	nt 3 DOA	Other ₄	Nursing H	lome 5	Reside	ence 6 🗸	Other:	Scene
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	ful Af	Certification:	1 X Natural	5 Pen	dina	(Month, Day,)	rear)		1	Yes 2	No					
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	d in Ster	튑	3 Suicide		ld not be ermined		ijury - At Home	o, raim, sa	oot, radiory, office	, bananig, oa	. 2	or Town,				,
	Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burnal - transi	වී	4 Homicide			(Specify)								4		
	n 24 l		(Check only	ertifying P	hysician:	To the best of m	y knowledge,	death occ	curred at the time, gation, in my opinio	date and pla	ice, and du	e to the cau	use(s) ar	nd manner a	as state e to the	d. e cause(s)
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-	00	- }	30. Name and address	ss of persor	n who com	pleted cause of	death (Item 23	Ba)							-	
	44		Victor Weedr						W. Baltimore	Street, B	altimore	MD 212	223			
		ate	31. Date filed (Month.		0		ar's Signature									
				W- /T	407											

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Year Cecil Rivers Claude March 4 2150 hrs Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death Heartland Health Care Center Prince Georges Hyattsville 8. Date of Birth (Month, Day, Yea 1933 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 262-44-8403 Davs Director 1 X M 2 🗆 F 78 November 7. Florida Usual Residence of Decedent 28a-f show at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director must be notified 1 X Yes 2 No Maryland | **Prince Georges** Hyattsville 10g. Citizen of What Country? 23a Funeral 6500 20783 United States Riggs Road Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status ed other than "natural", or iter event, the Medical Examiner 14. Race - American Indian Black, White, etc. 2 **X** No þ 1 Never Married 2 Married within 72 hours after Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates. **Black** 3 Widowed 4 X Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Secondary (0-12)

12th grade College (1-4 or 5+) Roofer Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ျှ David Malachi Rivers Mildred Be11 Lesesne other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) If item 27 Nancy Rivers Jones (Sister) 1311 Taylor Street, N.E.; Washington, D.C. 20017 March 19, 2012 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State ō Department of Important: If any injury or once. 4 Donation 5 Other (Specify) Chesapeake Crematory, Inc. Beltsville, Maryland 21. Signature Fineral Service Licensee 22. Name and Address of Facility R. N. Horton Company Morticians, Inc.;600 Kennedy Street, N.W.; Washington, D.C. 20011 CC0330 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Cerebrovascular Accident disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Atherosclerotic Cardiovascular Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last Hypertension as the burial-tran Due to (or as a consequence of): attending physician Physician/Medical certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Month Pregnant at time of death Other (specify) Year Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ate has been signed page 2 should be de 23e. Did tobacco use contribute to the cause of death? Completed by Hyperlipidemia 1 X Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? Dementia 24a. Was an certificate has performed? Yes 2X No or Attending Physician: The Laryngeal Carcinoma 1 Yes funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 X Nursing Home 5 Residence 6 Other (Specify) ပ 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at 28b. Time of Certificate: within 24 hours after death.

To the Funeral Director: After to completely filled in by the funer 28d. Describe how injury occurred XNatural 5 Pending 1 🗌 Yes Investigation Accident 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Crifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title 29d. Date signed (Month, Day, Year) 41867

Registrar DHMH 17 Rev 06-2011

Oney Zuniga, 31. Date filed (Month, Day,

M.D.; 4701 Randolph Road; Suite 216; Rockville, Maryland

ess of person who completed cause of death (Item 23a) (Type, Print)

2012

March

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 3 2012 5:00 A M Robert C. Strauss Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Maryland Bethesda Carriage Hill If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🛛 M 2 🗆 F Months Hours (Month, Day, Year 9-16-191 100 New York Director 213-38-4571 Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director or 28a-f sh notified a 1

Yes 2 □ No MD Montgomery Bethesda 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? ò ral", or items 23a or Examiner must be with 1 Funeral 5215 Cedar Lane 20814 United States permit. Page 1 and 2 should be filed within 72 hours after death a Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14 Race - American Indian Armed Forces?
1

Yes 2 □ No Black, White, etc. þ 1 Never Married 2 Married X Yes Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: WHITE Year or Dates. WWII 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Analytical Statistician Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ಲ Joseph Strauss Alma Swartz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard F. Strauss - Son Leo Chasse Way Framingham, Massachusetts 01701 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 🗶 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) King David Mem Park 3-4-2012 Falls Church, Virginia 21. Signature of Funeral Service Licensee Edward Sage1 22. Name and Address of Facility Danzansky-Goldberg Zorz M00910 1170 Rockville Pike, Rockville, Maryland 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Myocardial Infarction Medical Due to (or as a consequence of) Examiner Anemea Sequentially list conditions Due to for as a consequence cry dary, leading to immedicause. Enter Underlying 重 Exam Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury Coronary Artery Disease that initiated events resulting in death) Last and Due to (or as a consequence of) attending physician for use as the burial Physician/Medical Diabetes Mellitus Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year signed by the a 1 ☐ Yes ∠ ☐ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Metastatic Squamous Cell Cancer 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an this certificate has ral director, page 2: autopsy performed? Yes 2 X No 25. Was case referred to medical funeral director. Be 26. Place of Death (Check only one) examiner? Other: 4X Nursing Home 5 Residence 6 Other (Specify) Hospital 1 Yes 2 No မှ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 🗌 Yes 2 🗆 No 27. Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred After injury 1 X Natural 5 Pending Investigation Accident after death the 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide determined 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifie within 24 ho

To the Fune

completed fi (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and little of certifier 29c. License number 29d. Date signed (Month. Day, Year) 0 D35579 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Susan J. Miller - 8218 Wisconsin Ave., #305, Bethesda Md, 20814 31. Date filed (Month, Day, Year, State

DHMH 17 Rev 7/2009

Registrar

			Plea	se Type or I					•		egible.		
	-	For State	DHGwartill	State of Maryland / Department of Health and No. 3/16/12:BWW.McCo Certificate of Death						herital Hygierie			
		Tatale RegistraMFND#6perFH, 3/16/12; BMW, MoCo Certificate of Death 1. Decedent's Name (First, Middle, Last)							2. Date of D	eath	2012	3 Time of Death	
Physicia		Claire S							Month 3	Bay	2012	10:55 A M	
Medic Examin				give street and numb	er)		4b. City, Town, or	r Location of Death			ounty of Death		
	·.	3330 Nort	th Leis	ure World	Blvd.	#820	Silver	Spring		Mon	tgomer	У	
Funeral		5. Social Security N	umber	6. Sex 7	. Age (In yrs.	last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of B	irth	9. Birth Cou	place (State or Foreign	
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nd how at	7	Usual Residence of 10a. State	10b. County		10c. Cit	ty, Town or Lo	cation	1			10d. Inside City Limits		
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it. Partituer		4 Donation 5 Other (Specify) Garden Of Remembrance 3-11-12 Clarksburg, Maryland 21. Signature of Funeral Service Licensee Kurt Blake 22. Name and Address of Facility Edward Sagel Funeral Direction											
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature, or Ful	Heral Service Li		61ake M01477			ille Pike					
		23a. Part 1. Enter t	the disease, or	complications that ca	used the deat						1141 9 16	Approximate	
Physician/		Immediate Cause ((Final	nly one cause on eac	n line.	1 0/	Indiac	arch	4-How	ia		Interval Between Onset and Death	
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executed an and ria tran	xan	Cause (Disease or injury that initiated events c. Due to (or as a consequence of):											
	-	resulting in death)	Last		as a conseq	defice off.							
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certifi nding use a	n/M	IF FEMALE: 23b. Was decedent	pregnant	23c. If yes, outco			1			230	d. Date of d el iv	very	
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s that gned be de	by										bacco use contribute to the cause of death? ✓es 2 □ No 3 □ Probably 4 🛣 Unknown		
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To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the b.		building, etc. (Specify) City or Town, State)											
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tems	Funeral Director	1	11. Marital Status			edent Ever in	n U.S.	13. W	/as Decedent of I	Hispanic O	rigin? (Spe	ecify Yes or No	-			can Indian,	
after d ", or i	٤	2	1 Never Marr		ried 1 Tes	2 🗶 No		If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ▼ No Specify:						Specify:	, White, WH		
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			shock, or hea	rt failure. List o	complications that only one cause on e		death. Do no	ot entei	r the mode of dyl	ng, such a	s cardiac (or respiratory a	rrest,			Approximate Interval Between Onset and Death	
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To the Hospital or Attending Physician: The law requires that the death certificate be within 24 belows after death. Within 24 brouns after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the but.	10 B								t 3 🗆 DOA Ot	Other:							
	ie.		27. Manner of Deatl	h 5 🗌 Pendir	// // // // // // // // // // // // //	e of injury nth, Day, Yea	28b. Ti	me of jury	28c. Inju	k?		28d. Describe	d. Describe how injury occurred				
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)	-	-	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)							D34740			3-	3-5-2012			
		1			who completed car 1ds, MD -					Drive	, 01	ney, Ma	ry1a	and 20	0832		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar AMEND#19b, perFH, 3/14/12; EMW, MbCo Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** P^{M} 2012 9:10 Doris Scheinkopf 3 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Collingswood Nursing Home Rockville Montgomery If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 1 □ M 2 🛣 F Massachusetts Director 87 9-22-1924 031-12-9733 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Myolcal Examinar must be rediffed at 1 ☐ Yes 2 🛣 No Director MD Rockville Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 299 Hurley Avenue 20850 United States Funeral Pages 1 and 2 should be filed within 72 hours after dear ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: WHITE ≥ 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Secretary 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Abraham Hershfield Sarah Stone 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Eric Scheinkopf - Son 5801 Nicholson Lane, #704 N Bethesda, MD 20852 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages Department o Important: If i any injury or 1 Burial 2 ☐ Cremation 3 ☐ Removal from State injury or 3-3-2012 4 ☐ Donation 5 ☐ Other (Specify) Judean Mem Gardens Olney, Maryland 21. Signature of Funeral Service Licensee Fdward Sage1 22. Name and Address of Facility Edward Sagel Funeral Direction #M00910 1091 Rockville Pike, Rockville, Maryland 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner STIVE on if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last s a consequence of) Examine The law requires that the death certificate be executed and Due to (or as a consequence of) as the buria Box 68760. physician Physician/Medical attending IF FEMALE: use yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy jo Month Day Year 5 Other (specify) 0 □Yes 2 No the be detached 9 Unknown 9 Unknown σ. signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed certificate 1 ☐Yes 2 ☑ No 1 ☐Yes 2 ☐No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ٩ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica Completely filled in by the funeral

> State MAR 12 Registrar

31. Date filed (Month, Day, Year)

30. Name and address of person who con

29b. Signature and title of certifier

00062435

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2012 Year Physician/ Webster Sayler March Carmi Jr 6:00 am M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Frederick 8422 Edgewood Church Road Frederick Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours Mar 3^{Day,} 1933 217-28-5647 79 Mary Tand **Director** 1 **X** M 2 □ F or 28a-f show notified at 10d. Inside City Limits 10c. City, Town or Location Director Maryland Frederick Frederick 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code ò 10g, Citizen of What Country? "natural", or items 23a or edical Examiner must be Funeral 21702 U.S.A 8422 Edgewood Church Road death \ 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian. was Decedent Ever in U.S. Armed Forces? 1953-17 Kg ves 2 DNo 17 Ves, Give Year or Dates. Black, White, etc. ģ 1 Never Married 2 Married within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: White 3 Widowed 4 X Divorced Completed Medical 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) al Hygiene. I other than " went, the Mex Elementary/Secondary (0-12) College (1-4 or 5+) Mobile Cleaning Systems Carpet/Floor Maintenance 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F permit. Page 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or **** မ Smith Sr LaRue Carmi Webster Sayler Hattie 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13702 Jimtown Road, Thurmont Maryland 21788 19a. Informant's Name/Relationship (Type, Print) Carmi W. Sayler, III, Son 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Mar 10,2012 Frederick, Maryland Mt Olivet Cemetery 4 Donation 5 Other (Specify) Signature Reeney & Bastord P.A. Funeral Home 106 E Church Street, Frederick, <u>Maryland 217</u>01 23a. Part f. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Lung Cancer 1 year disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Examine Due to (or as a consequence of, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Day Month Year Pregnant at time of death 9 Unknown ed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Coronary Artery Disease 1 X Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has b director, page 2 s performed 1 ☐ Yes 2 ☐ No Yes 2 X No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 Yes 2 X No 1 Inpatient 2 I ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at s after death.

I Director: After the in by the funera Certificate: 28d. Describe how injury occurred 1 🗶 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a

To the Funeral C

completely filled Medical XCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D09689 March 7, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
A. Austin Pearre, Jr, M.D., 300 West Ninth Street, Frederick, Maryland 21701 32. Registrar's Signature

State

Registrar

31. Date filed (Month, Day, Year)

MAR 0 8 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / De		Mental Hyg	iene 2012	09359							
			riogistiai	ertificate of Death		Reg. No.								
	Physicia	n/	1. Decedent's Name (First, Middle, Last)		2. Date of Deat Month	h Day Year	3. Time of Death							
	Medic	al	Mary Antonia Saunders		March 6	1	9:27 P M							
	Examin	er	4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Dea	th	4c. County of Death	.1-							
	E		Kline Hospice House 5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	Mount Airy V) If Under 1 Year If Under 24 Hrs	8. Date of Birth	Frederic	olace (State or Foreign							
	Funeral Director		190-12-4644 1 \square M 2 X F 89 Yrs	Months Days Hours Min										
			Usual Residence of Decedent		June 17,	1922 Penr	sylvania							
	fand f s ho d at	tor	10a. State 10b. County 10c. City, Town or	Location			0d. Inside City Limits							
	Mary 28a-i otifie	Director		msville			1 ☐ Yes 2 💢 No							
	h the ka or be n		10e. Street and Number	10f. Zip Code	1	I0g. Citizen of What Coul								
	h wit	Funeral	11122 Innsbrook Way	21754		U.S.A.								
	r iter iner	F	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Never Married 2 ☐ Married 12. Was Decedent Ever in U.S. 1 ☐ Yes 2 【XNo	 Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer 	Specify Yes or No- to Rican, etc.)	14. Race - Americ Black, White,								
36	al", o	d by	3 ★ Widowed 4 □ Divorced 1 □ Yes 2 ► No If Yes, Give Year or Dates.	1 ☐ Yes 2X No Specify:		Specify: Whit	:e							
ŏ	hours natur lical I	lete	15. Decedent's Education 16a. De	cedent's Usual Occupation		16b. Kind of Business/Industry								
215	e. Ban "I	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	ve kind of work done during most of wo . DO NOT use retired)	orking	Corporate								
7	with /gien ner th		2 Exe	cutive Secretary		Government								
pu	e filec stal H ed otl	To Be	17. Father's Name (First, Middle, Last) Vincent Kinkela		ame (First, Middle, N									
3	uld by I Mer nark natic													
<u>⊠</u>	2 sho th and 27 is r traun			ailing Address (Street and Number or R 22 Insbrook Way,										
e,	and Heal tem 2		20a. Method of Disposition 20b. Place of Dis	sposition (Name of		20c. Location - City or To								
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any fijury or other traumatic event, the Medical Examiner must be notified at once.		1 Rurial 2 X Cremation 3 Removal from State cemetery, of	rematory or other place) litan Crematorium	- 1	Alexandria,								
a E	mit. F partm portal / injul	ì	21. Signature of Fineral ServiceLicense											
m	an De		21. Signature of Fineral Service Licenses of Facility ams P.A., Funeral Home Molesworth-Williams P.A., Funeral Home 26401 Ridge Road, Damascus, Maryland 20872											
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between											
CALL	Ph, sician/		Immediate Cause (Final disease or condition			Onset an								
_	Medical Examiner		resulting in death) Due to (or as a consequence of):											
		er	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):											
	ed nsit	Examiner	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease of injury											
	xecut n and ial-tra	Exa	that initiated events c. Due to (or as a consequence of):											
09	ate be executed physician and the burial-transit	dical	d											
376	ificate ig phy as th	Med	IF FEMALE:		-									
ق ×	eath certifica attending p	an/I	23b. Was decedent pregnant 23c. If yes, outcome of pregnancy	3 Ectopic pregnancy		23d. Date of deliv	,							
Bo	deati he att ned fo	Physician/Me		5 Other (specify)		Month Day Ye								
Ö	requires that the der been signed by the s should be detached		Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in Part I.	23e Did toh	id tobacco use contribute to the cause of death?								
ď.	res th signe d be d	d by	hypothyroid	, 5	1 ☐ Yes 2 ▼No 3 ☐ Probably 4 ☐ Unknown									
ğ	requi	Completed by	huna men cina		24a. Was an 24b. Were autopsy findings ava									
ecc	The law cate has page 2	mp	perideral vascular disease		autopsy prior to completion of cause of death?									
<u> </u>	i ician: The certificate rector, pag		25. Was case referred to medical	26. Place of Death (Ch	1 Yes 2	2X No 1 Yes	2 LI No							
Vita	Physicia this cert	To Be	examiner? 1 ☐ Yes 2 X No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpa	Other		ence 6 X1 Other (Specifi	Hospice							
of	g Phy er this		27. Manner of Death 28a. Date of injury 28b. Time	of 28c. Injury at	rsing Home 5 Residence 6 Other (Specify) Hospice 28d. Describe how injury occurred									
ou	endin sath. or: Aft the fui	fical	2 Accident Investigation	M 1 Yes 2 No										
Division of Vital Records, P.O. Box 687	spital or Attending P nours after death. neral Director. After th y filled in by the funera	Certificate:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office		tion (Street and Number or Rural Route Number, or Town, State)								
	pital o		X C. Attic Dhairin Table had for him black		and due to the neu	on (a) and manner as at at								
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 42 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	2ga. Certifier 1 Certifying Physician: To the best of my knowledge, dea (Check 2 Medical Examiner: On the basis of examination and/or in only one) 3 Certifying Nurse Practitioner: To the best of my knowled	estigation, in my opinion, death occurred	d at the time, date and	d place, and due to the ca	use(s) and manner stated.							
	To the within To the comp	2	29b. Signature and title of certifier	29c. License number	1	the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year)								
			15+100	н58132		March 7, 2012								
	6		30. Name and address of person who completed cause of death (Item 23a) (Typ-	e, Print)		-								
	1/2			reet - Suite 208,	Damascu	s, Maryland	20872							
	Stat Registra		31. Date filed (Month, Day, Year) MAR 0 8 2012 32. Registrar's Signature	Larens .										
	110913111		111111111111111111111111111111111111111	/										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Day 07 Physician/ Monti 03 TYRONE **SEEGERS** Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 3623 Silver park drive Suitland Prince Georges 5. Social Security Number If Under 1 Year If Under 24 Hrs. Funeral 6. Sex 7. Age (In vrs. last birthday) Date of Birth 9. Birthplace (State or Foreign 1 **X** M 2 □ F Hours Month, Pay, Year) 02/16/1952 Washington DC **Director** 579-72-2865 Usual Residence of Decedent or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director MD 1 X Yes 2 No Prince Georges Suitland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 3623 Silver Park Drive Apt103 20746 USA 11. Marital Status Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces 1 Yes 2 No If Yes, Give 6 Black, White, etc. 1 Never Married 2 Married Completed by 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify Black "natural", 3 Divorced 4 Divorced Year or Dates injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Termite Inspector Private Industry and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည James Seegers Rebecca Sanders permit. Page 1 and 2 should I Department of Health and Me Important: If item 27 is marl 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shirley Seegers / Wife 3623 Silver pArk Dr. Suitland MD 20746 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Lincoln Memorial 03/15/2012 Suitland, MD 22. Name and Address of Facility Tyrone J. Young Funeral Services 21. Signature of Funeral Service Lice MO1476 any Eads Street NE Washington DC 20019 Enter the disease, or or heart failure. List s that caused the e on each line leath. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock or heart fail Interval Between Onset and Death Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) Exami The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Day Year Pregnant at time of death 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? has performed 2 No 1 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific 25. Was case referred to medical **Division of Vital** Be 26. Place of Death (Check only one) Hospital: Other: မ 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: (Month, Day, Year) 1 Natural 2 Accident 5 Pending nours after death.

neral Director: Aff
illed in by the fur 1 Yes 2 No Investigation 3 Suicide 4 Homicide Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a

To the Funeral D

completed filled i Medical 29a. Certifier Qertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 012 30. Name and address of person who completed cause of death (Item 23a) (Type. 31. Date filed (Month, Day, Yea State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1	For Amend Item 26 per verb., 19925, 037 - State Registrar Ce	26/2012dhB allin and Nortificate of Death	Reg. N	10. 0010 0000
	Physicia	n/	1. Decedent's Name (First, Middle, Last) Vivian Lee Sperry		2. Date of Death March 13,	3. Tirhe of Death Day 2012 Year 8: 10 AM M
	Medic Examin		4a. Facility Name (if not institution, give street and number) 4734 Teen Barnes Road	4b. City, Town, or Location of Death Frederick	4	County of Death Frederick
is to	Funeral Director	- 1	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) $1 \square \text{ M 2X} = 91 \qquad \text{Yrs.}$	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Year) Jan. 13, 1	
	Aaryland 8a-f show tified at	O I	Usual Residence of Decedent 10a. State 10b. County Maryland Frederick Toc. City, Town or Loc Frederick	ocation	,	10d. Inside City Limits 1 ☐ Yes 2 ☒ No
	with the N 23a or 2 ust be no	Funeral Di	10e. Street and Number 4734 Teen Barnes Road	10f. Zip Code 21703		S.A.
036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	Armed Forces?	Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 XNo Specify:	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
Baltimore, Maryland 21215-0036	within 72 hours after death with the Maryland giene grent than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at the Medical Examiner	Completed	(Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during most of work O NOT use retired) ecretary	ing	Kind of Business/Industry Manufacturing
land 2	I be filed w fental Hygi rked othe tic event,	To Be	17. Father's Name (First, Middle, Last) Barnett S. Anderson		e (First, Middle, Maide he Brannon	
, Mary	d 2 should ealth and Με n 27 is mar l er traumati		19a. Informant's Name/Relationship (Type, Print) Mrs. Susan Sperry Rentzell, Dau: 47	ing Address (Street and Number or Run 742 Teen Barnes Ro	ad, Freder	or Town, State, Zip Code) ick, MD 21703
imore	Page 1 an ment of He ant: If iten ury or oth		20a. Method of Disposition 1 \(\begin{align*} \text{3 Burial 2 } \begin{align*} \text{Cremation 3 } \begin{align*} \text{Removal from State} \\ 4 \begin{align*} \text{Donation 5 } \begin{align*} \text{Other (Specify)} \end{align*} \]	osition (Name of matory or other place) ort Cemetery Mar.	Date 20c. 17, 2012	Bridgeport, W VA
Balt	permit. Depart Import any inj		21. Signator of Foreral Service Los ree M00255	Keeney and Basford 106 East Church St	d PA Funera t., Freder	al Home ick, MD 21701
	Ph_sician/ Medical Examiner	Examiner	23a, Part 1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. E. iter Underlying Cause (Disease or injury that initiated events C.	€ 4 D€ NOC 4		Approximate Interval Between Onset and Death
092	ate be exect hysician an the burial-tr	edical Ex	resulting in death) Last Due to (or as a consequence of): d.			
Box 68	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and real director, page 2 should be detached for use as the burial-transit			☐ Ectopic pregnancy ☐ Other (specify)	N.	, 23d. Date of delivery Month Day Year
s, P.O.	requires that th been signed by should be deta	by	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		o use contribute to the cause of death? 2 No 3 Probably 4 unknown
Division of Vital Records,	The law requate has beer page 2 shou	Completed			24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? No 1 ☐ Yes 2 ☑ No
/ital	ysician: The is certificate director, pag	To Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatie	26. Place of Death (Chec	ome 5 X Residence	6 ☐ Other (Specify)
on of \	ne ter		27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident Investigation 28a. Date of injury (Month, Day, Year) injury		28d. Describe how inj	
Divisio	To the Hospital or Attendir within 24 hours after death. To the Funeral Director: Af completely filled in by the fu	Certificate:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, so building, etc. (Specify)	treet, factory, office	28f. Location (Street a City or Town, Sta	and Number or Rural Route Number, ate)
_	ne Hospital or A in 24 hours after ne Funeral Dire pletely filled in b	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of t	stigation, in my opinion, death occurred a	at the time, date and pla lace, and due to the cau	ace, and due to the cause(s) and manner stated. use(s) and manner as stated.
•	To the with To the com		29b. Signature and title of certifier Done lum ms	29c. License number 2193 A		Date signed (Month, Day, Year) March 13, 2012
	12		30. Name and address of person who completed cause of death (Item 23a) (Type, A. SINELSON NO 65C. THOM	4 COMMUNA DE	. FRED	ERK K 90 21702
	Sta Registr		31. Date filed (Month, Day, Year) NAR 2 6 2012 32. Registrar's Signature	de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la		

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State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2 . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 3 Leona ("Lolly") Toll 2012 P^{M} 3:15 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 9120 Kittery Lane Montgomery Bethesda 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Days Hours Mir (Month, Day, Year) **Director** 121-48-7986 1 □ M 2 🛛 F 57 3-16-1954 New York Usual Residence of Decedent show 10a. State at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director notified 28a-f 1X Yes 2 □ No Bethesda MD Montgomery 10e. Street and Number 10f. Zip Code ms 23a or must be r 9 10g. Citizen of What Country? Funeral 9120 Kittery Lane 20817 United States items ? filed within 72 hours after death 12. Was Decedent Ever in U.S Was Deceue. Armed Forces? Yes 2 ♣ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Examiner Black, White, etc. ò þ 1 Never Married 2X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2X No Specify: WHITE "natural", Specify: Completed 3 Widowed 4 Divorced traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+ Director of Pre-School Education Be 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be file.
Department of Health and Mental H.
Important: If item 27 is marked any injury or care. 18. Mother's Name (First, Middle, Maiden Surname) ည Jack Gottlieb Goldie Hantman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Steven J. Toll - Spouse 9120 Kittery Lane, Bethesda, Maryland 20817 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, 4 ☐ Donation 5 ☐ Other (Specify) Judean Mem. Gardens 3-6-2012 Olney, Maryland 21. Signature of Funeral Service Licensee Jamie Arthurs 22. Name and Address of Facility Danzansky-Goldberg #M01163 1170 Rockville Pike, Rockville, Maryland 20852 First 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest enock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Metastatic Cancer of Unknown Primary disease or condition months Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) 12 Exam requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last and Due to (or as a consequence of): use as the burial nding physiciar Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy5 Other (specify) atter ģ in the past 12 months?
1 Yes 2 No Pregnant at time of death Month Day Year been signed by the s should be detached P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Division of Vital Records, 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an the Hospital or Attending Physician: The law page 2 has autopsy performed certificate 1 Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 1 Yes 2 X No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 \square Nursing Home 5X Residence 6 \square Other (Specify this 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred After 5 Pending 1X Natural work? 1 Yes 2 No 2 Accident
3 Suicide 24 hours after death. Prineral Director: Al Investigation empletely filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifie 🖾 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2. only one 200 29b. Signature and title o 29c. License number 29d. Date signed (Month, Day, Year) D0033293 3-5-2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Frederick P. Smith, MD -5454 Wisconsin Avenue, #1300, Chevy Chase Maryland 20815 31. Date filed (Month, Day, Year) State MAR 12 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) March Day +1 2012 Physician/ Thing, Sr. Robert L. Medical a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Anne Arundel Baltimore Washington Medical Center Glen Burnie Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number **Funeral** Days Months 90 **Director** 348-18-1044 1 🕅 M 2 🗆 F Sept. 11,1921 Illinois Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10a, State with the Maryland Director notified 1 Yes 2 X No MD Anne Arundel Severna Park 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 9 items 23a or ner must be n Funeral 21146 USA 731 Faircastle Avenue 12. Was Decedent Ever in U.S. 1942 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 X Married 1 Yes
If Yes, Give "natural", or 1945 White 1 Yes 2X No Specify: Specify: Completed 3 Widowed 4 Divorced Year or Dates er than "natur the Medical I 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Electrical Ith and Mental Hygien 27 is marked other the r traumatic event, the 5+ Engineer Be 18. Mother's Name (First, Middle, Maiden Surname) Maryland 17. Father's Name (First, Middle, Last) ၉ Lois Layton George F. Thing 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 731 Faircastle Avenue Severna Park, MD 21146 Department of Health Important: If item 27 Annette Thing / Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State March 12, 1 Burial 2 X Cremation 3 Removal from State injury or Baltimore, MD Metro Crematory, INC. 4 ☐ Donation 5 ☐ Other (Specify) 2012 22. Name and Address of Facility
Barranco & Sons, P.A. Severna Park Funeral Home
Severna Park, MD 21146 21. Signature of Funeral Service Licensee any in 23a. Part 1. Entering disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Cause (Disease or injury that initiated events resulting in death) Last the Hospital or Attending Physician; The law requires that the death certificate be executed burial-tra Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery □ Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Pregnant at time of death 5 Other (specify) Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? page 2 s autopsy performed 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: To 1 🗌 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28c. Injury at work?
1 Yes 28a. Date of injury (Month, Day, Year) 27. Manner Death 28b. Time of 28d. Describe how injury occurred After Natural 5 Pendina within 24 hours after death.

To the Funeral Director: Ai completely filled in by the fu Accident Investigation 3 Suicide 4 Homicide Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Wetlical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Noveac; mD 29d. Date signed (Month, Day, Year) 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) nacer : 301 Hospital Glan BurnemD e State MAR 09 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First Middle Last) 2. Date of Death Physician/ THOMPSON ERROL LAMONT 12:017M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Hospitalor 1timore Social Security Number 8. Date of Birth
(Month, Pay, Year)
Jan. 10, 1976 **Funeral** Age (In vrs. last hirthday 9. Birthplace (State or Foreign 216-04-6846 **Director** 1 X M 2 🗆 F 36 Washington, DC Usual Residence of Decedent show 10a. State notified at 10c. City, Town or Location 10d. Inside City Limits Director Maryland Prince George's Bowie 28a-f 1 Kes 2 □ No 10e Street and Number ò 10f. Zip Code or than "natural", or items 23a or the Medical Examiner must be r 10g. Citizen of What Country? Funeral 12619 Henderson Chapel Lane 20720 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. þ 1 🛮 Never Married 2 🗆 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) ye 1 and 2 should be filed within 7/s t of Health and Mental Hygiene. If item 27 is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Medical Technician Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 2 Thompson Earvin Leon Joyce Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code Joyce L. Thompson (Mother) 12619 Henderson Chapel Ln., Bowie, MD 20720 other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ò 1 X Burial 2 Cremation 3 Removal from State Department of Important: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Resurrection 03/16/2012 Clinton, MD 21. Signature of Funeral Service Lig 22. Name and Address of Facility Jordan Funeral Service. 4001 Benning Rd., N.E., Washington, DC 23a. Part 1. Enter the disease, or compared to the second failure. List only lications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. cause on each line Interval Betweer Immediate Cause (Final nset and Death Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day ed by the a detached i g Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of this certificate has I trail director, page 2 s perform death? Be 25. Was case ref red to medical examiner? 26. Pace of Dath (Check only one) 1 ☐ Yes 2 ☑ No Hospital 잍 1 Impatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes М 2 🗌 No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide within 24 hours after dear To the Funeral Director completely filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical

Records, To the Hospital or Attending Physician:

(Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗌 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) Name and address of person who completed cause of death (Item 23a) (Type, Print) 2401 M Belvedere ave ret

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2:18PM Year Mel omes Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death University of Manyland Medical Center Baltimore 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours (Month, Day, Year, 213-98-4043 Director 1**X** M 2 □ F 45 24. 1967 Feb. MD Usual Residence of Dece 28a-f show items 23a or 28a-f sho her must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 TNo MD Montgomery Kensington 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 10610 Wheatley Street 20895 filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Medical Examiner Armed Forces? Black White etc. 1 Never Married 2 Married ō ð Maryland 21215-0036 White If Yes, Give Year or Dates 1 Yes 2 No Specify: 'natural", Completed 3 Widowed 4 Divorced Decedent's Education 16a. Decedent's Usual Occupation 16b Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working I Hygiene. life. DO NOT use retired. Elementary/Secondary (0-12) College (1-4 or 5+) the Tow Truck Operator Self-Employed traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental I 2 James Daniel Welch, Sr. Mary C. McCarthy .. Page 1 and 2 should be tment of Health and Mer tant: If item 27 is marke 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bertha M. Welch/Wife 6734 Somerset Street, Harrisburg, PA 17111 Baltimore, other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of Important: If it any injury or o cemetery, crematory or other place) 1X Burial 2 Cremation 3 Removal from State March 2012 4 ☐ Donation 5 ☐ Other (Specify) John's Cemetery Silver Spring, MD 21. Signature of Funeral Service Licensee Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring.MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Poset and Death Immediate Cause (Final Ph. sician/ troke disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events Due to (or as a consequence of): 2 requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last physician s the burial Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year ☐ Pregnant at time of death☐ Unknown signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? Left venetricular assist device 24a. Was an page 2 s certificate has autopsy performe 2 🗌 No 1 \sum Yes Yes filled in by the funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? 2 No Other: |으 1 Xnpatient 2 -ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After 5 Pending 1 🗌 Yes 2 🗌 No Accident Investigation 6 Could not be Suicide 3 ☐ Suicide 4 ☐ Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certi-29d. Date signed (Month, Day, Year) 75066 140 3

Registrar
DHMH 17 Rev 06-2011

State

MMC

225. Greene St. Balthon MD 2420

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Cardiac

Sun

🗷. Registr**a**r's Sig

Julia Terhune

31. Date filed (Month, Day, Year)

MAR 12 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 3 Physician/ Jack Warshaw Α. M 2012 0850 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Brighton Gardens Chevy Chase Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth Days (Month, Day, Year) Director 013-05-6696 1 XM 2 □ F 91 1 - 7 - 1921Boston, MA ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 72 hours after death with the Maryland 10a. State 10c. City. Town or Location 10d. Inside City Limits Director MD 1 X Yes 2 No Montgomery Chevy Chase 10e. Street and Number 10f. Zip Code 109. Citizen of What Country? Funeral 5555 Friendship Blvd #433 20815 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, Armed Forces?

1 X Yes 2 If Yes, Give Black, White, etc. ģ 1 Never Married 2 X Married 2 🗌 N Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 ☐ Widowed 4 ☐ Divorced WWIT Specify. WHITE "natural". Completed Year or Dates. 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

Deputy Assistant other traumatic event, the Medical 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Federal Government 12 Secretary of Labor other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file th and Mental h Tille Mogulesky Elie Warshaw 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra Eileen Ivey Sirota - Daughter 5417 Kirkwood Dr., Bethesda, <u>Maryland 208</u>16 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) 3-9-2012 Judean Mem. Gardens Olney, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Edward Sagel Funeral Direction Jamie Arthurs M01163 1091 Rockville Pike, Rockville, Maryland 20852 Part Letter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph sician/ Respiratory Failure one year disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or i that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 the as attending IF FEMALE: nse 23c. If yes, outcome of pregnancy
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To the Funeral Director: A:
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Registrar

29b. Signature and

Richard D. Schubert

MAR 12 2012

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

29c. License number

3301 New Mexico Avenue, NW Ste 348, Washington, DC 20016

11441

29d. Date signed (Month, Dav. Year)

3-8-12

12-02215

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Chad M. Whitne		1- For State Registrar		of Marylan		artment of rtificate of		nd Men		Reg	g. No. 201	2 0936
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	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Armed Forces? Black, Whit																
D C	1 Never Married 2XXMarried 1 Yes 2X No If Yes, Give 1 Yes 2X No Specify: Specify: A:										Afr	ican-					
E C		15. Decede	nt's Edu	ucation	ites.	16a.	Deceder	nt's Usua	al Occupa	ation			16b.	Kind of Busi		rican_	
	(Spe		est grad	le completed) College (1-	4 or 5+)	-	(Give kin life. DO l			uring mos	t of worki	ing	De	pt. of	f Ar	my	
De C	12th					M	anag	er						.S. G	over	nment	
9	17. Father's Name (i									18. Moth		e (First, Middle nie Mat					
	19a. Informant's Na	ame/Relations	hip (Typ	e, Print)		19b	. Mailing	Address	(Street a	nd Numbe	er or Rura	al Route Numb	er, City	or Town, Sta	te, Zip (Code)	
	Audrey J. Burke/Sister-In-Law 7520 Dover Lane, Lanham, Maryland 20706																
	20a. Method of Disposition 1 Bunial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) Harmony Mem. Park 20c. Location - City or completely and completely Landover, Mem.																
	21. Signature of Fu	- 2	License	-16	CC031	6	22.1	Heni Heni	Addres	Was	hing	ton & S	ons	Co.,	Inc.	. a . a.	
٦	23a. Part 1. Enter t	he disease, o	r compli	ications that c	aused the							nr respiratory a		mingic		Approximate	
	shock, or hear Immediate Cause (disease or condition	Final	only one	4.4	card	ol is	chor	NIA								Interval Betw Onset and D	
	resulting in death)		•	Due to (or as a con	sequence o	of):	1714							7		
	Sequentially list co	nditions,	t	Ar	terio	scler	Ohl	dis	CYFE						_		
Adillie	if any, leading to in cause. Enter Under Cause (Disease or	rlying	(Due to (or as a con	sequence o	oi):										
	that initiated events resulting in death) I		(Due to (or as a con	sequence o	of):								\top		
completed by Physician/Medical E			L	d											_		
N C	IF FEMALE:			0 - 16 1		-3.1									-		
Clair	23b. Was decedent in the past 12	months?	2			Fetal death		Ectopic Other (s.	pregnanc	у				23d. Date Mont		,	ear
ly S	1 🗌 Yes 2 9 🗍 Unknown	No No		9 🗌 Unkn		01 40411		311101 (0)									
y y	Part II. Other signif	icant conditi	ons cor	ntributing to de	eath but no	t resulting i	n the unc	lerlying	cause giv	en in Part	1.	23e. Did	tobacco	use contrib	ute to th	he cause of de	ath?
ננ												1 🗆	Yes	2 □ No 3	Pro	bably 4	Jnknown
eldu.												24a. Was	psy	pri	ere auto or to co ath?	psy findings a mpletion of ca	vailable ause of
	05 14/											1 🗌 Yes	ormed?			2 🗆 No	
ם ם	25. Was case referre examiner? 1 X Yes 2 D	ed to medical DNo	1-	ospital:	Innationt '	Z ED/O	tnationt	3 🗆 D	Otho	r.		k only one)	idoras	e [] Other	(Cncair	d	
1 Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of injury 28c. Injury at work?									7								
20	1 Natural 2 Accident 3 Suicide	Invest	igation					М	1 🗆	Yes 2 🗆	-						
27. Manner of Death 1										er,							
Cal	29a. Certifier 1	Certifying	g Physic	cian: To the be	est of my k	nowledge, o	death occ	cured at	the time,	date and	place, an	d due to the c	ause(s)	and manner	as state	ed.	
меа	(Check 2	Medical □	Examin	er: On the bas	is of examir	nation and/o	r investiga	ation, in	my opinio	n, death o	ccurred at	the time, date e, and due to t	and place	ce, and due to	o the ca	use(s) and man	ner stated.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

State Registrar 29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AMber Morshall '7600 Carroll Ave 32. Registrar's Signature 31. Date filed (Month, Day, Year) MAR 1 9 2042

MD

29c. License number

69194

Avance Talcoma Park MD

29d. Date signed (Month, Day, Year)

20912

12-01984 Jose Zapata Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No. Registrar 1, Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death Physician/ Month Jose Ε. 2118 hrs Zapata March 8, 2012 Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death c. County of Death Bethesda Montgomery Suburban Hospital 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Director 578-15-9784 72 Country)El Salvador 1X M 2 F Yrs Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 Yes 2 No 28a-f show Silver Spring i. Pages 1 and 2 should be filed within 72 hours after death with the Maryland tracent of Health and Mental Hygiene.
rtant: If item 27 is marked other than "natural", or items 23a or 28a-f she y or other traumatic event, the Medical Examiner must be notified at once. Montgomery 10g. Citizen of What Country? 10e. Street and Numbe 10f. Zip Code 12115 Foley Street 20902 uneral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 Never Married 2 X Married Yes Specify: White 1 Yes 2 No specify: Salvadorean 4 Divorced If Yes, Give Year 3 Widowed 2 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Baltimore, MD 21215-0036 12 Maintenance Worker Maintenance Services 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ezequiel Zapata Be Elida Pastora 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Maria Zapata Lopez/Wife 12115 Foley Street, Silver Spring, MD 20902 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 20a. Method of Disposition Date 1 X Burial 2 Cremation 3 Removal from State March 13 2012 Silver Spring, MD Gate of Heaven Cemetery 4 Donation 5 Other Specify: 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc.
500 University Blvd. W., Silver Spring, MD 20901

Approximate Interval permit. 21. Signature of Funeral Service Licenses Approximate Interval 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Between Onset and failure. List only one cause on each line Medical Death a. Head and Neck Injuries Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical UNPENDED AMENDED attending physician for use as the burial -3/13/12 · BMW M-C 8perINF The law requires that the death certificate be Box 68760 ac. If yes, outcome of pregnancy 23d. Date of delivery IF FEMALE 23b. Was decedent pregnant in the 2 Fetal death Day 3 Ectopic pregnancy Year Live birth Month past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown signed by the a 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, P.O. ۵ 1 Yes 2 No 3 Probably 4 Unknown Completed has been s 24b. Were autopsy findings available 24a Was an prior to completion of cause of autopsy death? performed? ✓ Yes 2 No 1 Yes 2 No this certificate 26 Place of Death (Check only one) 25. Was case referred to medical Fo the Hospital or Attending Physician: æ examiner? Hospital: 1 Inpatient 2 🗸 ER/Outpatient 3 Other Nursing Home 5 Residence 6 Other 1 Yes ٩ 28a. Date of Injury FOUND: 28d. Describe how injury occurred 28b. Time of Injury 28c. Injury at Work? After 27. Manner of Death Certification: Subject fell FOUND: 1 Natural Division within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 Yes 2 V No 5 Pending Mar 8, 2012 2030 hrs 2 🗸 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide 6 Could not be or Town, State) 12115 Foley St, Silver Spring, MD (Specify) At home determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Wedical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c, License number ho O.C.M.E. March 9, 2012 30. Name and address of person who completed cause of death (Item 23a) Ling Li, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 32. Registrar's Signature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Raj D. Auluck March 2012 2142 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Shady Grove Adventist Hospital Rockville Montgomery 6. Sex If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Tndia 8. Date of Birth 7. Age (In vrs. last hirthday) Funeral (Month, Da Feb. 8, Day, Year) 1944 Days Hours Months **Director** 68 214-75-2438 Usual Residence of Decedent show 10a. State 10b. County notified at 10c. City. Town or Location 10d. Inside City Limits Director 28a-f MD Montgomery Gaithersburg 1 X Yes 2 No 10e. Street and Number 10g. Citizen of What Country? ò 10f. Zip Code event, the Medical Examiner must be Funeral items 23a 19828 Bramble Bush Drive 20879 India 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ò þ 1 Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates 'natural", Specify: Asian Completed 3 X Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working and Mental Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Ownhome Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Department of Health and Ment Important: If item 27 is marked any injury or other. Shanti Devi Chet Ram 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Manjeet Battu / daughter 19828 Bramble Bush Drive Gaithersburg, MD 20879 20a. Method of Disposition 20h. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Final Journey Crematory 3/26/12 Woodbine, MD 21. Signature of uneral Service Ligensee Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, M M01651 MD 21029 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ asotradion disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) cause. Enter ungeriving Cause (Disease or iinjury that initiated events respi burial-trans and Due to (or as a consequence of resulting in death) Last physician Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 X No Month 4 ☐ Pregnant at time of death 9 ☐ Unknown detached 1 ☐ Yes ∠ y 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Cerebrovascular 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of 24a. Was an autopsy mellitus dia betes certificate Yes 2 No Yes Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 1200 Other: Certificate: To 1 Tyes Impatient 2 - ER/Outpatient 3 - DOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 24 hours after death. Funeral Director: A 1 🗌 Yes filled in by the Investigation Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completed within 24 Curtifying Nurse Practioner: To the best of my knowled

Registrar

HMH 17 Rev 7/2009

Doctoris

D41162

29d. Date signed (Month, Day, Year)

March 22, 2012

20874

Gantimo

MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

19529

32. Registrar's Signature

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Gandi

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death MARCH 24, 2012 Physician/ PAULA MARIE ADLE 2136 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death UPPER CHESAPEAKE MEDICAL CENTER HARFORD BEL AIR Social Security Number If Under 1 Year I If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Min Hours 2136 **Director** 212-56-9627 1 M 2 XF 62 AUGUST 29,1949 MARYLAND 28a-f show 10b. County 10c. City, Town or Location must be notified at 10d. Inside City Limits Director 1 🗆 Yes 2 🕱 No MD HARFORD BEL AIR 10e. Street and Number 10g. Citizen of What Country? Funeral items 23a 1302 TURRET ROAD 21015 USA death \ 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🗶 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, þ 1 Never Married 2 X Married Yes Yes, Gi Baltimore, Maryland 21215-0036 Specify: WHITE 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 Divorced Year or Dates Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12TH OFFICE MANAGER OFFICE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည PAUL T. CYPHERT MARIE F. KAHLER of Health and ? I item 27 is ma 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) TIMOTHY ADLE SPOUSE 1302 TURRET ROAD BEL AIR, MD.21015 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1
Department of Important: If it any injury or o 1 Burial 2 X Cremation 3 Removal from State ATLANTIC CREMATORY 4-2-2012 GLEN BURNIE, MD. 4 Donation 5 Other (Specify) SCHIMUNEK FUNERALHOME OF BEL AIR 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 08681 610 W. MACPHAIL ROAD BEL AIR, MD. 21014 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ Herpes disease or condition resulting in death) MKnown Medical Due to (or as a consequence of) Examiner sewatia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury nding physician and use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ___ in the past 12 months?
1 Yes 2 No Month Year signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Respiratory Frullere Division of Vital Records, Completed 1 Yes 2 No 3 Probably 4 Unknown D'abetes Mellitru 24b. Were autopsy findings available prior to completion of cause of ate has t autopsy performed Yes 2 ☐ Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 **7** No ပ္ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ithin 24 hours after uca....

o the Funeral Director: After thi 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work' 2 Accident
3 Suicide Investigation
6 Could not be 2 No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier D0065421 March, 24, 2012 MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 500 Upper Chesapake Drue Bul Am, Maryland 21014 R. Fister, MD State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death March March Physician/ 2012 Year 23 Josephine Albanese 10:50 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Ellicott City 2811 Green Shade Court Howard 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Hours 186-07-8478 Director 92 1 □ M 2 🗶 F April 7, 1919 Pennsylvania Usual Residence of Deced 28a-f shov 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits notified at Director 1 🗆 Yes 2 🔀 No MD Howard Ellicott City 10 10e. Street and Numbe 10g. Citizen of What Country? ms 23a or must be r Funeral 2811 Green Shade Court 21042 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1. Marital Status 14. Race - American Indian. Examiner Armed Force Black, White, etc. -1 ☐ Yes 2 🔀 No If Yes, Give by 1 Never Married 2 Married filed within 72 hours after all Hygiene. Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify Specify: White "natural", 3 X Widowed 4 Divorced Completed Year or Dates Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) the 12 Homemaker Own Home other 1 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Tirendi Anna Giangreco Louis and lis ma 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health item 27 Annette Grauman/daughter Green Shade Court Ellicott City, MD 21042 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date Page 1 ō 50 1 Burial 2 Cremation 3 Removal from State Department of Importants If any injury or once. Crest Lawn Memorial Gar. 3/28/2012 Marriottsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Harry H. Witzke's Family F.H. Inc 21. Sig lature of Funeral Service Licer 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Par L. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one caus, on each line. Immediate Cause (Final Onset and Death Physician/ Cetro Dunto disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions Examine if any, leading to immediate cause, Enter Underlying Due to (or as a consequence of) Cause (Disease or injury attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Year Pregnant at time of death Dav No the 9 Unknow Unknown P.O. signed by Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician: The law has performed certificate Yes 2 No 1 Tyes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 2 No 1 🗌 Yes ျပ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify, this 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 2 Accident
3 Suicide
4 Homicide the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Registra DHMH 17 Rev 06-2011

State

(Check only one

29b. Signature and title of certifie

31. Date filed (Month, Pay,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

4 E. Kolling Crossing Sucte 30

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Salome

Suite 307. Bistimire MD

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Hawkins

29d. Date signed (Month, Day, Year)

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DO FACA

Anderson Frank

			Please	Type or Pri										
			For State	State of M	aryland		artmer <i>tificat</i>			and M	lental Hy		Break Supp. 8	2 09373
			Registrar 1. Decedent's Name (First, Middle, Last	t)		Cel	lincat	e oi L	Jeani		2. Date of De	Reg. No	0.	3. Time of Death
В	Physicia Medic		Frank I) .	Anderson 3 Month							3. D		ar lina Q.
1000	Examin		4a. Facility Name (if not institution, give						Location o	of Death			County of D	
- mark	Funeral		Franklin Square 5. Social Security Number 6. Se	HOS 0 1-	e (In yrs. la:	st birthday)	If Unde	r 1 Year	oale If Under:		8. Date of Bi	rth		Birthplace (State or Foreign
Ĺ	Director		Usual Residence of Decedent	∑ M 2 □ F	60	O Yrs.	Months	Days	Hours	Min.	(Month, Di			aryland
	yland -f sho ied at	ctor	10a. State 10b. County		10c. City,	, Town or Lo		_						10d. Inside City Limits 1 ☐ Yes 2X No
	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	Director	Maryland Baltimo	ore		Park	ville 10f. Zip					10a. C	itizen of What	
		Funeral	2455 Woodcroft Roa	ad					21234			_	JSA	, , .
980		by	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent 8 Armed Forces? 1 Yes 2 If Yes, Give Year or Dates.		i			spanic Orig n, Mexican Specify:	gin? (Spec , Puerto F	cify Yes or No Rican, etc.)			American Indian, /hite, etc. White
5-0	2 hour "natu edical	Completed	15. Decedent's Ed (Specify only highest gra			16a. Dece	kind of wo	rk done d	ation furing most	of workir	ıg	16b. l	Kind of Busine	ess/Industry
121	ithin 7 iene. r than	Com	Elementary/Secondary (0-12) 12 years	College (1-4 or 5	5+)		O NOT use	_ ′	ment (Opera	ator	Inte	ernatio	onal Local 37
and 2	be filed we sental Hygi ked othe	To Be	17. Father's Name (First, Middle, Last) Morton Anderson	7 100-2			·· <u>·</u>	1		er's Name	(First, Middle			
	d 2 should be fil alth and Mental 27 is marked r traumatic eve		19a. Informant's Name/Relationship (Ty, Sandy Anderson	oe, Print) wife	€								r Town, State, Marylar	
more,	permit. Page 1 and 3 Department of Healt Important: If item 2 any injury or other once.		20a. Method of Disposition 1 ☐ Burial 2X Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		ce	ace of Dispo emetery, cren View C	natory or c	ther place	e)	Marc 2012	# 27,	I	-	or Town, State Maryland
Balti	permit. P Departm Importa any inju		21. Signature of Funeral Service Licenso		lly	25	drine'	ld I Yddre i	ruhera ers Po	al HC	me Of	Dund	dalk,P.	
1			23a. Part 1. Enter the disease or comp shock, or heart failure. List only or	lications that caused be cause on each line	d the death								•	Approximate Interval Between
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蒸		iner	Sequentially list conditions, if any, leading to immediate	Due to (or as	a conseque	ence of):								
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. Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be within E4 hours after death. To the Luneral Director: After this certificate has been signed by the attending physic completely filled in by the funeral director, page 2 should be detached for use as the but the butter of the completely filled in by the funeral director, page 2 should be detached for use as the butter of the butter of the butter of the butter of the butter of the butter of the butter of the butter of the butter of the butter of the butter of the butter of the butter of the butter of the butter of the butter of the butter of the butter of the butter of the butter of the butter of the butter of the butter of the butter of the butter of the butter of the butter of the butter of the butter of the butter of the butter of the butter of the butter of the butter of the butter of the butter of the butter of the butter of the butter of the butter of the butter of the butter of the butter of the butter of the butter of the butter of the butter of the butter of the butter of the butter of the butter of the butter of the butter of the butter of the butter of the butter of the butter of the butter of the butter of the butter of the butter of the butter of the butter of the butter of the butter of the butter of the butter of the butter of the butter of the butter of the butter of the butter of the butter of the butter of the butter of the butter of the butter of the butter of the butter of the butter of the butter of the butter of the butter of the butter of the butter of the butter of the butter of the butter of the butter of the butter of the butter of the butter of the butter of the butter of the butter of the butter of the butter of the butter of the butter of the butter of the butter of the butter of the butter of the butter of the butter of the butter of the butter of the butter of the butter of the butter of the butter of the butter of the butter of the butter of the butter of the butter of the butter of the butter	Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome 1 ☐ Live Birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal	death 3 Ectopic pregnancy							23d. Date of Month	delivery Day Year
s, P.O.	res that th signed by d be detad	by	Part II. Other significant conditions co	ntributing to death b	ut not resu	ulting in the u	nderlying (cause giv	ren in Part I		1			e to the cause of death?
ord	w requi	Completed									24a. Was	an	24b. Were	autopsy findings available
Rec	The lav ate has page 2	mo										psy ormed? 2 🖳 N	death	to completion of cause of n? Yes 2 \(\square\) No
tal	cian: ertifica ector,	Be	25. Was case referred to medical examiner?	Hospital:					ace of Deat	th (Check				
ξ	Physi r this c eral dir	<u>ان</u>	1 ☐ Yes 2 ☑ No 27. Manner of Death	1 Minpati 28a. Date of inju	iry 2	ER/Outpatier 28b. Time of		OA Othe	4 L Nu		ne 5 🗌 Resi 8d. Describe		6 Other (Sp	pecify)
ouc	ath. r: Afte	icate	1 Natural 5 ☐ Pending 2 ☐ Accident Investigation	(Month, Day	y, Year)	injury	M	work'		- 1	ou. B 0001150	no tr ingai	,, 000000	
Division of Vital Records,	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Certificate:	3 ☐ Sulcide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Inju building, etc	ury - At hor c. (Specify)	me, farm, stre	eet, factory	y, office		2	8f. Location (City or To			Rural Route Number,
_	Hospite 24 hour Funera etely fille	Medical	29a. Certifier 1 Certifying Phys (Check only one) 3 Certifying Nurs	ner: On the basis of e	xamination	and/or invest	tigation, in	my opinio	n, death oc	curred at	the time, date	and place	e, and due to t	he cause(s) and manner stated
	To the within To the Complete		29b. Signature and title of certifier					License		е апо ріас	e, and due to			onth, Day, Year)
			D trauth	eller.	DIM	1.D.		73	664	3			3-22	- 2012
	101		30. Name and address of person who co							2				
	Stat	e	31. Date filed (Month, Day, Year)	32. Figistra	ar's Signatu	Ire			sive	1501t	Imore	. m	D 31	1331
	Registra		MAR 27 20	12 Jane	w	6. p	all	<i>p</i> .						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First. Middle, Last) 2. Date of Death 3. Time of Death Day 2012 Year Physician/ March 22, Charles John Alexander 22:30 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Suburban Hospital Bethesda If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours Director 022-16-0782 1 **X** M 2 □ F April 6, 1924 Massachusetts Usual Residence of Decedent show 10b. County 10c. City, Town or Location item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at Director Maryland 1 Yes 2 X No Bethesda Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7815 Aberdeen Road 20814 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian. Armed Forces' þ 1 Never Married 2 X Married 1 X Yes If Yes, Give be filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White IIWW 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) U.S. Government 5+ Attorney Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles M. Alexander Anna T. Garbarino 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) and 2 s Health a James A. Alexander/Son 6100 Kennedy Drive, Chevy Chase, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If its
any injury or of cemetery, crematory or other place) March 25. 1 Burial 2 X Cremation 3 Removal from State Montgomery Crematorium Bethesda, Maryland 4 Donation 5 Other (Specify) 2012 21. Signature of Funeral Service Lice Robert A. Pumphrey Funeral Home, Bethesda-Chevy Chase, Inc. Willia M01173 7557 Wisconsin Avenue, Bethesda, Maryland 20814 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final 3 weeks Ph_sician/ Chronic Obstructive Pulmonary Disease Exacerbation disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine Daw to (or as a donsoquence of): frank, leading to immedicause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical that the death certificate be Box 68760 IE EEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Dav Year Pregnant at time of death P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ĝ Atrial Fibrillation Records, 1 X Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of Hypertension The law autopsy death? perform performed? Yes 2 🔼 No certificate 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) 1 Yes 2 X No Certificate: To 1 X Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28h Time of 28c. Injury at 28d. Describe how injury occurred X Natural 5 Pending work ivision 1 Tyes 2 🗌 No Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) D0060117 March 23, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Park, M.D. 8600 Old Georgetown Road, Bethesda, Maryland 20817

Registrar

DHMH 17 Rev 06-2011

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2012 Physician/ Month Violet Blackburn 11:10 a March Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 3244 Rocks Chrome Hill Road Jarrettsville Harford 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Age (In yrs. last birthday) **Funeral** Hours 244-40-1459 Director 1 □ M 2 🛣 F March 10,1921 91 Usual Residence of Decedent North Carolina ms 23a or 28a-f show must be notified at 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD 1 ☐ Yes 2X No Harford Jarrettsville 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 3244 Rocks Chrome Hill Road 21084 USA ral", or items 2 Examiner mus 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces Black, White, etc. 1 Never Married 2 Married ş 1 Yes 2 XNo filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: "natural", Specify: white Completed 3 🕅 Widowed 4 □ Divorced Year or Dates nit. Page 1 and 2 should be filed within 72 hours artment of Health and Mental Hygiene. ortant: If item 27 is marked other than "natur injury or other traumatic event, the Medical. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Seamstress Glen Eagle Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ္ Benjamin Franklin Lang Eliza South 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 s
Department of Health a
Important: If item 27 is
any injury or 2603 Rocks Road Forest Hill, Maryland 21050 Margaret Hudler/daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place) Metro Crematory 3/26/2012 Baltimore, Maryland 22. Name and Address of Facility ature of Funeral Service Licensee Stephanie Custer Cremation Society of MD.INC. 299 Frederick Road Baltimore, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence a): Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Exami The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of) physician a Physician/Medical P.O. Box 68760 as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery in the past 12 month 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) ____ or Pregnant at time of death Month Day Year the a g Unknown Unknown signed by t Id be detach Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò Division of Vital Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe certificate Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 1 Yes Other: ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of I Director: After to a in by the funeral Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) filled in within 24 hours a To the Funeral D Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier

Registrar DHMH 17 Rev 06-2011

State

no completed cause of death (Item 23a) (Type, Print)

Crossroads, Suite

East Kolling

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ BROWN ax BAN Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death YOSPICE Baltimore GILCHRIST 10W500 If Under 1 Year If Under 24 Hrs. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign **Funeral** Min. Months Hours 614 **Director** MARYLand and Mental Hygiene. is matural", or items 23a or 28a-f show is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho amy citant: If item 27 is marked other than "natural", or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Baltimore Md 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral LMORA Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 12. Was Decedent Ever jar U.S. 14. Race - American Indian, Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DQ NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) ine RC Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ BROWN 19a. Informant's Name elationship (Type, Print) Paug 9b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date ☐ Burial 2 ☐ Cremation cemetery, crematory 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory List only one cause on each line. shock, or heart failur mmediate Cause (Final disease or condition Interval Between Onset and Death Physician/ Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been simpled. for use as the burial-transi Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No Day Month Year Pregnant at time of death page 2 should be detached g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 Yes eral Director: After this certific filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be 2 No Other: 1 Yes 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) NOSOL C Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of injury 28c. Injury at 28d. Describe how injury occurred Natural 5 \square Pending work? 2 🗆 No Accident Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Signature and title of certifier 2012

Registrar
DHMH 17 Rev 06-2011

State

Date filed (Month

N

tow (ON MM)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32.

egistrar's Signatur

SASKING.

CUARM

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 09377 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day 2012 Year March 25, Betty Jean Bull 11:57 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 12704 Holdridge Road Silver Spring Montgomery 5. Social Security Number 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** 239-64-9641 71 **Dírector** 1 □ M 2 🔀 F Jun 7, 1940 North Carolina Usual Residence of Deceden 28a-f shov 10a. State 10b. County 10c. City, Town or Location notified at 10d. Inside City Limits Director MD Silver Spring Montgomery 1 Yes 2 XNo 10e. Street and Number 10f. Zip Code ms 23a or must be n 10g. Citizen of What Country? Funeral 12704 Holdridge Road 20906 USA oe filed within, fental Hygiene arked other than "natural", or items -- vent, the Medical Examiner m 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 XNo Specify. Specify: White Completed 3 🛮 Widowed 4 🗆 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Bookkeeper Accounting Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental ပ Asa Smith Edith Roark If item 27 is marke or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Laurie Shrader/daughter 12704 Holdridge Road Silver Spring, MD 20906 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Department of Important: If i any injury or c 1 Burial 2 XCremation 3 Removal from State Final Journey Crematory 03/27/12 Woodbine, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee coing Home Cremation Service P.O. Box 784 MO1251Beverly L. Heckrotte, P.A. Clarksville, MD Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph. sician/ disease or condition Respiratory Failure week Medical resulting in death) **Examiner** Congestive Heart Failure 1 month if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Exami Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical certificate be P.O. Box 68760 the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No Day Year Pregnant at time of death 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Metastatic Breast Cancer 1 X Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has page 2 autopsy performed? this certificate 1 Yes 2 No 1 Yes 2 No the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 X No Other: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred eral Director: After ifiled in by the funer work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending injury ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide within 24 hours a

To the Funeral C

completely filled Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signatoe and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar

31. Date filed (Month, Day, Year)

NAR 2 7 2012

Peter B. Sherer, M.D.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3921 Ferrara Dr. Wheaton, MD 20906
32. Registrar's Signature

D21910

March 26, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
AMEND ITEM#2perpHYS, G925, 372772012, WS
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death Physician/ Medical Facility Name (if not institution, give street and number 4b. City Town, or Location of Death **Examiner** 4c. County of Death Social Security Numbe 8. Date of Birth If Under If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Age (In vrs. last birthday 1 □ M 2 🛣 Days 212-50-2770 97 Min (Month, Day, Year) 08/24/1914 North Carolina Director er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Harford County Bel Air 1 Tes 2 No Maryland 10e, Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 400 Ellis Lane United States 21014 death 12. Was Decedent Ever in U.S Armed Forces? . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. 3√2 Widowed 4 □ Divorced Specify: White Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Co. nd Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Fawn Grove Manufacture Seamstress 10 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be filer and Mental H is marked oth 2 Arthur M. Duncan Lydia E. Absher 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Heatth ar Important: If item 27 is any injury or other trau Karen Long (Daughter) 11967 Blanchard Rd., Greenwood, Delaware 19950 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 03/27/2012 Bel Air Mem. Gdns Bel Air, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Evans Funeral Chapel & Cremation Services-BelAir
3 Newport Drive, Forest Hill, Maryland 21050 Cerns 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on ear Immediate Cause (Final Onset and Death relimonic Phy ician disease or condition resulting in death) Medical (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or iinjury Examine Due to (or as a consequence of) sician and burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical Box 68760 as the IF FEMALE: es, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ The law requires that the death Month Pregnant at time of death Day Year Yes the Unknown 9 Unknown P.O. þ Qther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à pe Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performe within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page 1 🗌 Yes To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other 1 \(\text{Yes} ပ 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 27. Manuer of Death 28a. Date of injury (Month, Day, Year) 28b. Time of. Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Accident 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: to the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Expaniner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Pray tioner: To the best of my knowledge, death occurred at the time, date and place, and due to the place(s) and manner as stated. 29a. Certifier (Check 3 | only one 29b. Signatur 10 State . Date filed (Month, Day, Year 7 2 Registrar

the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, To the Funeral Director: completely filled in by the

31. State Registrar

Medical

4 Donation 5 Other Specify: Holls	Hill Memorial Mar.2	
2) Signature of Funeral Service Licensee	22. Name and Address of Facility Ambro	ose Funeral Home Inc.
Talun am Start	1328 Sulphur Spring I	Road Arbutus Maryland 21227
23a. Part I. Enter the disease, or complications that caused the death. Do r failure. List only one cause on each line.		
Immediate Cause (Final disease or condition resulting in death) a. Hanging Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Liseess or injury that initional events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.		
UNPENDED AMENDED		
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 4 Pregnant at time of death 9 Unknown	2 Fetal death 3 Ectopic pregnancy 5 Other (Specify)	23d. Date of delivery Month Day Year
Part II. Other significant conditions contributing to death but not resulti	ng in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown
		24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?
25. Was case referred to medical	26 Place of Death (Check only	one)
examiner?	Outpatient 3 DOA Other Nursing H	
1 Natural 5 Pending FOUND: Day, Year) No. 19, 2013		d. Describe how injury occurred bject hanged self
Z Accident investigation	in the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of th	Location (Street and Number or Rural Route Number, City or Town, State) 11 Stone Throw Way, Elkridge, MD
29a. Certifier 1 Certifying Physician: To the best of my knowledge, done) 2 Medical Examiner: On the basis of examination and/or and manner stated.	eath occurred at the time, date and place, and du investigation, in my opinion, death occurred at the	e to the cause(s) and manner as stated. e time, date and place, and due to the cause(s)
29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
Carde Harean	O.C.M.E.	March 18, 2012
30. Name and address of person who completed cause of death (Item 23a		24222
	W. Baltimore Street, Baltimore, MD	21223
31, Date filed (Month, Day, Year) MAR 2 7 2012 January 32, Registrer's Signature	Ked	
OCME	RIGINAL	

0411 hrs

Yes 2 X No

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2012 Year Physician/ March 18, 12:15 PMM Virgie Lee Bowers Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Frederick **Examiner** 4c. County of Death Frederick 9217 Baltimore Road 8. Date of Birth (Month, Day, Year) Aug. 17, 1925 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 7. Age (In yrs. last birthday, Days Hours 223-30-1668 86 Maryland Director 1 □ M 2 🗓 F 28a-f show 10b County 10d. Inside City Limits aţ 10c. City, Town or Location Director Examiner must be notified Frederick Maryland Frederick 1 Tes 2 No 10e. Street and Number 10f. Zip Code 21704 5 10g. Citizen of What Country? items 23a Funeral 9217 Baltimore Road U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes XX No If Yes, Give 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. , or . þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: 3 XWidowed 4 ☐ Divorced Specify. "natural" Completed Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired)

Owned & Operated (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) General Store of Health and Mental Hygien fitem 27 is marked other th Be 18. Mother's Name (First Middle, Maiden Surname) Maude Heffner 17. Father's Name (First, Middle, Last) William Murphy 19a. Informant's Name/Relationship (Type, Print) 19b Mailing Address (Street and Number or Rural Route Number, City or Toylo, State Zio Code) 9223 Baltimore Road, Frederick, MD 21/04 Mrs. Delores Thompson, daughter 20a. Method of Disposition

1 X Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If if any injury or o Clustered Spires Cem. Mar. 21, 2012 Frederick, MD 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee 2Keeney Adama Bally ford PA Funeral Home 106 East Church St., Frederick, MD 21701 M00255 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) aldas Medical Due to (or as a consequence of Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) that initiated events Due to (or as a consequence of): resulting in death) Last burialattending physician for use as the buria Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months
1 Yes 2 No Month Day Pregnant at time of death signed by the a ld be detached f 9 Unknown 1 ☐ Yes ∠ ■ 9 ☐ Unknown P.O. Ather significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by e Hospital or Attending Physician: The law requires t 24 hours after death. e Funeral Director: After this certificate has been sign letely filled in by the funeral director, page 2 should be Records, 1 🗌 Yes 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an his certificate has to director, page 2 st autopsy Yes . Was case referred to medical examiner? Division of Vital Be 26. Place of Death (Check only one) 24 No 1 Yes ပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 ☐ Yes 2 ☐ No 27. Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred Natural 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 🖵 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) March 19, 2012 30. Name and address of person who compl

Registrar
DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 2012 11:26 A M March Bell, Joseph Samuel Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Cecil Co. 172 Center Street Apt. Cecilton 2 C If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth Social Security Number 7. Age (In vrs. last birthday) **Funeral** (Month, Day, Months Davs Hours Maryland 1**X**□ M 2 □ F Yrs. Director 220-20-3282 83 Usual Residence of Decedent show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland ms 23a or 28a-f sho must be notified at Director 1 Yes 2X No Cecilton Ceci1 MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral Apt. 2C 21913 United States 172 Center Street "natural", or items 12. Was Decedent Ever in U.S. Armed Forces?

1 □ Yes 2 □ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 Yes 2XX No Specify. Specify. 3 X Widowed 4 □ Divorced White Year or Dates permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical. 15. Decedent's Education 16a, Decedent's Usual Occupation 16b Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Crown Cork & Elementary/Seconday (0-12) 8 Years College (1-4 or 5+) Seal Co. Machinist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည John T. Bell Catherine A. Kreik 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 324 Hackberry Drive New Castle, DE (Son) Samuel J. Bell, Jr. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 🖫 Burial 2 🗆 Cremation 3 🗀 Removal from State 3/28/2012 Lutherville, MD Sater's Baptist Cem. 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee ²². Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 500C 7922 Wise Ave. Dundalk, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final cardiovescular Physician/ Atheno disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner 12 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Lue to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last nding physician Physician/Medical Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ō in the past 12 months? Month Year Day Pregnant at time of death the 1 ☐ Yes ∠ ☐ 9 ☐ Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown been si 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy perform death? 1 Yes 2 No this certificate Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No ဂ္ဂ 1 Inpatient 2 ER/Outpatient 3 DOA funeral Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred After 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined

Division of Vital thin 24 hours after death.

the Funeral Director: At mpleted filled in by the fu within 2

To the I

completed

31. Date filed (Month, Day, Year) State MAR 27 2012 Registrar

Medical

29a. Certifier

only one)

3 🗆

29b. Signature and title of certification

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) , bruce Obe har

32. Registrar's Signatur

251

1 💆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

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S, Bohamia Ave, Lecylton, and

29d. Date signed (Month, Day, Year)

March 26, 2012

29c. License number

Registrar

DHMH 17 Rev 06-2011

State

AMON

31. Date filed (Month, Day,

hances

ss of person who completed cause of death (Item 23a) (Type, Print)

6701 N,

M

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day Morsh 2012 3:15 A M Nancy L. Buchman Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Rock Spring Village Forest Hill Harford Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** 214-22-9777 86 Director 1 🗆 M 2 🔀 F Vrs 03/22/1926 Balt., MD show at 10c. City, Town or Location 10d. Inside City Limits Director notified 28a-f the Many 1 Yes 2 No MD Harford Forest Hill 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? þ 23a Completed by Funeral f Health and Mental Hygiene. item 27 is marked other than "natural", or items 23s other traumatic event, the Medical Examiner must i 1 Colgate Drive 21050 USA permit. Page 1 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces Black White etc. Yes 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes Give Specify: 3 XWidowed 4 Divorced White Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Clerical Secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ John Harvey Kimmel, Sr. Florence M. Sellers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carol L. Heflin - Niece Department of Health Important: If item 27 any injury or other tr 3037 Sharon Rd., Jarrettsville, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 03/23/2012 Atlantic Crematory Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) Schimunek Funeral Home 22. Name and Address of Facility 610 W. MacPhail Rd. Bel Air, MD 21014 23a. PM 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or injury that initiated events burial-transi and Due to (or as a consequence of) resulting in death) Last attending physician I for use as the buria Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be e 24 hours after death. Funeral Director: After this certificate has been signed by the attending physicia Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ signed by the atter Day Year Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 Yes 2 No To the Hospital or Attending Physician: I within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) 1000 examiner? Hospital 2 No Other: 4 Nursing Home 5 Residence 6 POther (Specify) LIVING 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Mann Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending Acciden
Suicide Investigation Accident M 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined

Registrar DHMH 17 Rev 06-2011

State

29a. Certifier

(Check

only one) 29b. Signature and ti

30. Name and address of person who completed cause o

death (Item 23a) (Type, Print)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

DOU68235

3/23/2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ MARCH 21.2012 7:30 AM PAUL BALDWIN Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death **QUEEN ANNES** CORSICA HILLS NURSING HOME CENTERVILLE If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 **X** M 2 □ F Days Hours 140nth 3ay 1919 NEWTHYJERSEY Yrs. **Director** 049- 22-1488 92 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director CENTERVILLE MD. **QUEENS ANNES** 1 Yes 2 No 5 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 21617 205 ARMSTRONG AVENUE USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 No
If Yes, Give Black, White, etc. ö þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: WHITE "natural", Completed 3 Widowed 4 Divorced Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Megonee. Elementary/Seconday (0-12) College (1-4 or 5+) UNKNOWN SALES MANAGER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Page 1 and 2 should be MARY BURKE WOODSON BALDWIN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARK BALDWIN 300 HOLLY STREET CENTERVILLE, MD. 21617 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) ATLANTIC CREMATORY 3-27-2012 GLEN BURNIE, MD. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility MILLER-DIPPEL FUNERALHOME, INC. BALTO. MD. 21206 ROAD itions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease or complic Approximate shock, or heart failure List only one Interval Between Onset and Death Immediate Cause (Final Ph_sician/ rosclerois EVERE disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of): attending physiciar Physician/Medical Division of Vital Records, P.O. Box 68760 as the l IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death use 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No jo Month Day Pregnant at time of death should be detached the by 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗆 Yes 2 🗆 No 3 🗆 Probably 4 🗗 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page 2 autopsy performed' Yes 2 No funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 4 hours after death.

*uneral Director: After the ted filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a To the Funeral I To the Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

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State Registrar 29b. Signature and title of certif

31. Date filed (Month, Day,

person who completed cause of death (Item 23a) (Type, Print)

BAYlis

MARIE

R168529

6095 Maishaleedr, Elkridge.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death March Physician/ 23 20°12 3:20p M Ε. Bourne Roy Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death Examiner 4c. County of Death Harwood Hospice of the Cheaspeake Anne Arundel 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Social Security Number 6. Sex 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days (Month, Day, Year) Aug. 18, 1942 MD 217-40-2666 69 **Director** 1 □**X**M 2 □ F ms 23a or 28a-f show must be notified at 10c. City, Town or Location 10d. Inside City Limits Oa. State 10b. Count Director MD Harford Joppa 1 Yes 2 No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral USA 21085 406 Bonham Road items death \ 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Examiner Black, White, etc. 0 þ 1 Never Married 2 Married filed within 72 hours after Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: White "natural", Specify: 3 Widowed 4 X Divorced Completed Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) State of Maryland Il Hygiene. I other than " went, the Me Elementary/Secondary (0-12) College (1-4 or 5+) Computer Programmer MVA12th traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental I : Page 1 and 2 should be fill tment of Health and Mental tant: If item 27 is marked 2 Mae Donuie Stephens William Emmett Bourne 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21122 8431 Hall Road Pasadena MD Henneth Bourne /son other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Bayview Crematory 3/26/12 1 Burial 2 🔀 Cremation 3 🗆 Removal from State Department o Important: If any injury or once, ō Baltimore MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 300 Mace Ave. Balto. Connelly Funeral Home of Essex 21221 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final MELANDIN Physician/ STAGE disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** BROWN Sequentially list conditions, Examine n any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence oi). the burial-transit Due to (or as a consequence of): resulting in death) Last physician Physician/Medical The law requires that the death certificate be Box 68760 as attending IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death signed by the at id be detached for Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? has page 2 ospital or Attending Physician: The la hours after death.

neral Director: After this certificate ha ly filled in by the funeral director, page. 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2. No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury_at 28d. Describe how injury occurred Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident Investigation 3 Suicide
4 Homicide Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a

To the Funeral II

completely filled Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practition for the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License numbe 3/2 d cause of death (Item 23a) (Type, Print) 30. Name and address of person who cor

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State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

12-02395 Rodrick Burden

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Rodrick Burden	State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No. 2 1 2 1938
Physician/	Registrar 2. Date of Death 3. Time of Death
Medical Examine	Rodrick Antonio Burden March 24, 2012 rear 2352 hrs
	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County or Death 4c. County or Death 4c. County or Death
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign
Director	217.39.0324 1XM 2 F 18 Yrs. Months Days Hours Min. 8.2.1993 Country/10
	Usual Residence of Decedent 10a State 10b County 10c City, Town or Location 10d. Inside City Limits
ow any	1 X Yes 2 No
yland F sho	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?
the Maryland is or 28s-f sho tiffed at once.	842 W. Favotte Street 21201 U.S.A.
with the 23s se noti	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes specify Cuban Mexican, Puerto Rican, etc.) White, etc. White, etc.
r death with or items 23 must be no	1 Never Married 2 Married Armed Forces? 1 Yes 2 No 1 Yes 2 No Specify: No Specify: No Specify: No Specify:
s after	3 Widowed 4 Divorced in Tes. 2 The Tes. 2 The Specify.
"natu Exan	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/industry
5-0036 ed within 72 hour lygene. other than "natu the Medical Exan Completed	12 Student High School
121 d be fill ental l arked arked	
MD 21 d 2 should dith and Me n 27 is ma numatic er	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, Citylor Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, Citylor Town, State, Zip Code) 19b. Mailing Address (Street and Number or Rural Route Number, Citylor Town, State, Zip Code) 19b. Mailing Address (Street and Number or Rural Route Number, Citylor Town, State, Zip Code)
and 2 and 2 lealth trem 2 traum	20a. Method of Disposition
Baltimore, M permit. Pages 1 and 2 Department of Health Important: If iten 2 injury or other traum	1 Sourial 2 Cremation 3 Removal from State Crematory or other place) 4 Donation 5 Other Specify: Crematory or other place) 1 Finity Cemetery 3-31-2012 Dundalk, MD
Baltimo permit. Pag Department Important: injury or ot	4 Donation 5 Other Specify: 21. Signature of Funeral Service Litensee 22. Name and Address of Facility The P.A.
F. F. P. Per OD	21. Signature of Funeral Service Utensee 22. Name and Address of Facility 23. Name and Address of Facility 24. Name and Address of Facility 25. Name and Address of Facility 25. Name and Address of Facility 26. North five rule Batto MD 21216
Physician	23a. Part I. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death
Medical Examiner	Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):
Maria Maria Maria Maria Maria Maria Maria Maria Maria Maria Maria Maria Maria Maria Maria Maria Maria Maria Ma	h ·
9	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause
ted J ansit Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):
oe executed cician and urial - transit dical Ev	d. #20
be executed be executed sician and urial - transi	UNPENDED #28a,per me,g928 6-15-12 sm
cords, P.O. Box 68760 aw requires that the death certificate thas been signed by the attending physication by Physician/Me	IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23d. Date of delivery Month Day Year
X 66 th certi	past 12 months? 4 Pregnant at time of death 5 Other (Specify)
Bo ne deat the at	1 Yes 2 No 9 Unknown 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?
P.O.	
Records, The law requires ficate has been sig	24a. Was an 24b. Were autopsy findings available
tal Records crian: The law requirect certificate has been ector, page 2 should	autopsy performed? 1 ✓ Yes 2 No 1 ✓ Yes 2 No
Reifficate	
Vital ysician ysician directo	examiner? Hospital: Inpatient 2 FR/Outnatient 3 DOA Other
n of Vital Rec ling Physician: The I After this certificate! funeral director, page	27 Manner of Death 28a Date of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred
ion itendia leath. for: /	1 Natural 5 Pending Investigation Investigation Pending Investigation Investigation Investigation Pending Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investigation Investig
Division of Vital Records, P.O. spiral or Attending Physician: The law requires that towns after death. After this certificate has been signed by filled in by the funeral director, page 2 should be detachartification: To Re Completed by B.	28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Suicide 6 Could not be determined (Specify) Local Street 28f. Location (Street and Number or Rural Route Number, City or Town, State) 800 block of West Fayette Street, Baltimore, MD
Divisior Bospiral or Attend 24 hours after death Funeral Director: stely filled in by the	
	(Check only one) 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
To the within To the compl	
	O.C.M.E. March 25, 2012
	30. Name and address of person who completed cause of death (Item 23a)
	Ling Li, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223
Stat Registra	10 m 0 m 0040

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ 0555AM 2012 20 ONT Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner t Has nos 00 8 If Under 24 Hrs. 5. Social Security Number 1 Year 8 Date of Birth 9. Birthplace (State or Foreign 6. Sex . Age (In yrs. last birthday) If Under **Funeral** Min (Month, Day, Year) 12/18/1939 1 M 2 D F 207-30-5359 Pennsylvania Director 72 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1X Yes 2 □ No MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 1415 Locust Street 21226 **USA** 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Marital Status Black, White, etc. 1 Never Married 2 X Married Yes Yes, Give 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify 3 Widowed 4 Divorced Completed White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) unkn. Mason Masonry Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 0 unkn. Annie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Billings / Son 305 Forest Hill Road, Red Lion, PA 17356 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Chesapeake Crematory 3/24/2012 Beltsville, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Dorota Marshall Maryland Cremation Services, PO Box 1413Baltimore, MD 21203 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. ocard Immediate Cause (Final Physician/ 10 disease or condition Medical resulting in death) Examiner 2014 Sequentially list conditions Examiner rrany, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events the Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and hed for use as the burial-trar Due to (or as a consequence of) resulting in death) Last Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) Pregnant at time of death 1 Yes 2 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an this certificate has autopsy perform death? 2 🗆 No ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital ည 1 🗌 Yes 2 XNo 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b Time of Certificate: 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After 1 Natural work? injury 5 Pending Accident Investigation the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined building, etc. (Specify) City or Town, State) 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) orch 20, Zalz 0033061 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) 3001 5 Jeann 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar M DHMH 17 Rev 06-2011

ORIGINAL

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND ITEM 1 Der PHYS G941 7/18 (2013 WS State of Maryland Department of Health and Mental Hygiene for State Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2012 Zahra Kazemi Bayani Physician/ Month March 23 2:56 A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Shady Grove Adventist Hospital Rockville If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) September 10, 1920 Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🗓 F Days Months Hours 218-08-7573 91 Iran **Director** Usual Residence of Decedent or 28a-f show notified at 10a. State 10d. Inside City Limits with the Maryland Director 10b. County 10c. City, Town or Location 1 X Yes 2 ☐ No Maryland Montgomery Rockville 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? an "natural", or items 23a or Medical Examiner must be Funeral 14601 Pinto Lane United States 20850 filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 🕅 No Specify: If Yes, Give Year or Dates Specify: White Completed 3 X Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 h
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "ns
any injury or other traumatic event, the Medic (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Mahmoud Kazemi Afsarmoluk Salour 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Arasteh Hekmat / Daughter 14601 Pinto Lane, Rockville, Maryland 20850 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State March 27, 1 🔀 Burial 2 🗀 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Parklawn Memorial Park 2012 Rockville, Maryland 22. Name and Address of Facility Robert A. Pumphrey Funeral Home, Rockville, 300 West Montgonery Avenue, Rockville, Maryland 20850 21. Signa ure of Juneral Ser ice Licensee M01619 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Phylician cardiac disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner respirator Sequentially list conditions, it any, reading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Hospital or Attending Physician; The law requires that the death certificate be executed Cause (Disease or linjury that initiated events Piradion Due to (or as a consequence of): resulting in death) Last the burial by Physician/Medical curebrovascular Division of Vital Records, P.O. Box 68760 attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy Day Pregnant at time of death 1 Yes 2 Unknown 5 Other (specify) the be detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 : has autopsy performed? certificate 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ၀ Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 🗸 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. the only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) ၉ March 23, 2012 D0064478 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7 Medical Car Dr Rochville MD 20850 9901 Fise hatsion mehari MD 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 7/2009

Registrar

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123/126

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) Arlie Wayne Chadwell, Jr 2. Date of Death 3. Time of Death Physician/ narci Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death HOSPITA Giereral Baltimore Taryland If Under 1 Year If Under 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** onth, Day, Year) 8/11/69 1 🕅 2 🗆 F 216-76-5366 42 Hours Min. **Director** MD Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at. 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD N/A Baltimore Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1819 Light Street Funeral 21230 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 2XXNo Black, White, etc. 1 Never Married 2 Married þ If Yes Give 1 ☐ Yes > No Specify: White 3 Widowed 4XXDivorced Specify: Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Construction Heating and A/C Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) Arlie Wayne Chadwell, Sr. Gail Morris 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1808 Byrd Street, Baltimore MD 21230 Gail Taylor / Mother Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Ardent Crematory or other pla 3/27/2012 Hanover Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22 Name and Address of Facility Charles L. Stevens Funeral Home, Inc 1501 E. Fort Avenue, Baltimore MD 21230 21. Signature of Funeral Service Licensee Victor P. Doda 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Hospital or Attending Physician: The law requires that the death certificate be executed ig physician and as the burial-tran that initiated events resulting in death) Last Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) atter for u in the past 12 months?
1 ☐ Yes 2 ☐ No 4 ☐ Pregnant 9 ☐ Unknown Pregnant at time of death Month Day Year 1 Yes 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy perform death? 2 🗌 No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? ဂ 2 No Other: 1 Pinpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No Accident 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide Investigation 24 hours after deat Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined Medical 1 Wertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier completed (Check within 2 3 Gertifying Nurse Fractioner: To the best of my knowledge de 29c. License number 89 (e. 4.3 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar Rehit Oform

31. Date filed (Month, Day

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Go Maryland Greneral Hospital

12-02336 Ronell A. Chanev

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Onell A. Chan	Су	1- For State Registrar	amend #16a&b	Percel	artment of He	aith and Mer 23//2012 JH	ital Hygiene İ	Reg. No. 201	2 0939
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realear Exam		4a. Facility Name (if not institu			4b. Cit	y, Town, or Location	March 21 of Death	4c. County of Dea	1714 hrs
		Johns Hopkins Hos	pital		Ва	Itimore			
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any		Usual Residence of Decedent 10a. State 10b. Coun		10c. City,	Town or Location				10d. Inside City Limits
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ne Maryland or 28a-f show Ifed at once.	rect	10e. Street and Number	1 01	. 1		Zip Code		10g. Citizen of What Co	111
MD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f sho mastic event, the Medical Examiner must be notified at once.	Funeral Director	1110 GOR 11. Maritar Status	SUCH AW	<u> </u>		21218	gin? (Specify Yes or N	U 5 Fg	
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21215-0036 uld be filed within 72 hours afte Mental Hygiene. marked nither than "natural", c event, the Medical Examiner	Completed	10th			Unemp1c	yed		Unemploy	ed
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Baltimore, Dermit. Pages I as Department of Hee Important: If ite		4 Donation 5 Other 21. Signal of Funeral Service	Specify:		Iffin Com		4/2/201	Turdon	o, N.C.
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ox 6876 eath certificate attending phy for use as the b	an/N	23b. Was decedent pregnant in past 12 months?	1 Live birth		2 Fetal deat	h 3 Ectopic	pregnancy	23d. Date of deliver Month	y Day Year
Box 687 death certific the attending p	Physician/I	1 Yes 2 No 9 U	Jnknown 9 Unknown	at time of dea	other (Sp.	pecify)		1	
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Sion Mtendi death. ctor:	atio		nding Mar 20, 201		2300 hrs	1 Yes 2 ✔			
Division of Vital Records, tal or Attending Physician: The law requires after death. al Director: After this certificate has been ited in by the funeral director, page 2 should	Certification:	det	uld not be termined (Specify) Lo		me, farm, street, factor	ry, office building, etc		Street and Number or Ru tate) East 21st Street, Balti	ral Route Number, City
Hospid 24 hour Funer: tely fill		4 Homicide 29a. Certifier 1 CertifyIng 1	Physician: To the best of r		·	ne time, date and place			
Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical	one) 2 Medical Ex	taminer:On the basis of ex- and manner stated	amination and	d/or investigation, in n	ny opinion, death occ	urred at the time, date	and place, and due to th	e cause(s)
	Σ	29b. Signature and title of certif	ier // \		29	O.C.M.F.	ÖÖNE	29d. Date signed (Mod	nth, Day, Year)
	ļ	30. Name and address of perso	1 Ky JA	1 y lee	. 0	O.C.M.E.	WAS INVESTIGATED IN	March 23, 2012	
HV		Theodore M. King, Jr		,	,	. Baltimore Stre	et, Baltimore, MD	21223	
Sta		31. Date filed (Month, Day, Year	32. R gistr	ar's Signature	8. parks	,		-,-	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 09392 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 03 2012 Garrick Carroll Chase 20:13 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Carroll Hospital Center Westminster Carroll Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth g. Birthplace (State or Foreign Days Hours Min. **™** M 2 □ F Months (Month Day Year) 05/10/1956 Country) 55 Director 215-64-1754 Usual Residence of Decedent Show 10a. State within 72 hours after death with the Maryland 10b. County notified at 10c. City, Town or Location Director 10d. Inside City Limits 28a-f 1

Yes 2 □ No MD Carrol] Westminster ö 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? event, the Medical Examiner must be Funeral items 23a 76 Pennsylvania Avenue, Apt. 107 21157 USA 12. Was Decedent Ever in U.S. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1X Never Married 2 ☐ Married ò þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural", Completed 3 Widowed 4 Divorced Specify: Black 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) n/a n/a Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental Important: If item 27 is marked of any injury or other traumatic eve once. 2 Lewis William Chase, Sr. Patricia Ellen Cross 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lewis Chase, Jr./brother 66 Charles St., Westminster, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) White Rock Cemetery 03/24/2012 Sykesville, MD of Fund ral Service L 21. Sgnature 22. Name and Address of Remixtts Funeral Home and Chapel, 412 Washington Road, Westminster, MD 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final ardrongo patry Onset and De th Ph sician/ Severe disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Esque, tially list our cities is, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Dav Year Pregnant at time of death the ; been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? After this certificate has in funeral director, page 2 s autopsy performed? 2 -No 1 Tes 2 = N Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: ဂ္ဂ 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 \square Pending Accident 1 🗌 Yes 2 🗌 No Investigation filled in by the 24 hours after deal Funeral Director: Suicide 8 🗌 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \square Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed (Check 3 within 2 To the I the only one 29b. Signature and title of certifie 29c, License number 29d. Date signed (Month, Day, Year) eelo 52035 Morch 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GHACKO 295 Stoner Avenue, Suite 103, Westminster, MD 21157 31. Date filed (Month, Day, Year, 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

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Baltimore,	nt of h t: If ite		20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 □ F	Removal from State	cemetery, cren	sition (Name of natory or other place	ce)			City or Town, State		
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ä	Der Der any		John J. He	efer, Jr.		L302 Nati	onal Hwy.	, LaVale	e, MD	21502		
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68760	nat the death certificate to be by the attending physicate by the attending physicate to be tached for use as the	Completed by Physician/Medic		1								
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ă	Hospital or Attendi 24 hours after death. Funeral Director: A etely filled in by the fi	sal C	29a. Certifier 1 Certifying Physic	cian: To the best of my know	visales dooth	non-read at the time	o date and place on	d due to the sou	no(n) and mann	por an etated		
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transi	Medical Certificate:	(Check 2 Medida Examine	er: On the basis of examination Practitioner: To the best of	on and/or invest	tigation, in my opinie	on, death occurred at	the time, date and	d place, and due	e to the cause(s) and manner stated.		
	To the within 7 To the comple		29b. Signature and title of certifie	0 /		29c. Licens	e number	2	9d. Date signed	(Month, Day, Year)		
)		1	jun			06 332			19,2012		
	671		30. Name and address of person who co	mpleted cause of death (Itel	n 23a) (Type, F	Kent A	Je Con	mort	and	MD 21502		
	Sta	e	31. Date filed (Month, Day, Year)	32. Registrar's Stone	ature				/ \			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Myrtle Mae Coghill	1- For State Registrar	tate of Marylan	d / Departm Certific			Mental H	_	leg. No. 20	12 0939
Physician/ Medical Examiner	Myrtle M. C	oghill					2. Date of Dea Month March 25	Day Year , 2012	3. Time of Death 1155 hrs
,	4a. Facility Name (if not instituti Carroll Hospital Cente	er			o. City, Town, or Lo Westminster			4c. County of I	
Funeral Director	5. Social Security Number 310-30-7964	6. Sex 7.	7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 79 Yrs. Months Days Hours Min.			1			
ow any	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town						10d. Inside City Limits
the Maryland a nr 28a-f show tified at once. Director	MD Ca	rroll	Syk	esvil	10f. Zip Code		1	0g. Citizen of What	1 Yes 2 X No
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygeine. Important: If item 37 is marked other than "matural", or items 33a nr 28a-f sho injury nr other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	247 Obrecht 11. Marital Status 1 Never Married 2 X M	12. Was Decede			21784 Decedent of Hispa , specify Cuban, N	ınic Origin? (Sp		USA 14. Race - A White, e	American Indian, Black,
urs after des tural", or i miner mu 1 by Fu	3 Widowed 4 Div	2 X No		es 2 X No s	2455.4	rork done	Specify:	White	
5-0036 ed within 72 hour Mygiene. other than "natu he Medical Exam	Elementary/Secondary (0-12)			during mos	t of working life. D	O NOT use retir		Hair Sa	•
21215-0036 21215-0036 21 Mental Hygiene. in merited other than ic event, the Medica	17. Father's Name (First, Middle Charles E.	Shelton						Maiden Surname)	1011
MD 21 nd 2 should alth and Me m 27 is ma aumatic en	19a. Informant's Name/Relations Wallace Lero		usband	247 (Obrecht H	nd Number or R Rd., Syl	ural Route Nurr cesvill	nber, City or Town, Se, MD 217	84
Baltimore, MD semit Pages I and 2 sho Department of Health and Important: If item 27 is injury or ruther traumati	20a. Method of Disposition 1 X Burial 2 Cremation 4 Opnation 5 Other S	pecify:	State cremat	ory or other	on (Name of cement place) emetery		Date 30/2012	20c. Location - Cit Shiple	
2. A	21. Sign ture of Funeral Sirvice	censee		22 Nar Bu 1	ne and Address of Trier-Que	Facility Een Fune	eral Hor	me & Crem	atory, P.A. , MD 21784
Physician /Medical :xaminer	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):								
19	or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate or immediate or immediate or immediate. Due to (or as a consequence of):								
0, be executed sician and burial - transit	cause. Enter Underlying Cause (Disease of injury that initiated events resulting in death) Last	c. Due to (or as a con	sequence of):						
60, te be executed ysician and burial - transit	UNPENDED	d AMENDED							
	IF FEMALE: 23b. Was decedent pregnant in th past 12 months? 1 Yes 2 ✓ No 9 Unk	e 1 Live birth 4 Pregnant	ome of pregnancy 2 at time of death 5		death 3 (Specify)	Ectopic pregnan	су	23d. Date of deli Month	very Day Year
P.O. Be as that the degree by the e detached f	Part II. Other significant conditi	9 Unknown	ath but not resulting	in the und	erlying cause give	n in Part I.			e to the cause of death?
Records, P The law requires 1 ficate has been sign , page 2 should be c							24a. Was a autops	n 24b. Were	autopsy findings available to completion of cause of
Division of Vital Records, tal mr Attending Physician: The law requirers after death. Tal Directur: After this certificate has been side in by the funeral director, page 2 should bertification: To Be Completed	25. Was case referred to medical examiner?					Death (Check or	1 Yes 2		
n of Viding Physical ding Physical directal dire	1 Yes 2 No 27. Manner of Death 1 Natural 5 Death	Hospital: 1 Inpat	jury 28b. T	ime of Injur	y 28c. Injury at		8d. Describe h	Residence 6 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	ther:
Visi	2 Accident Inves 3 Suicide 6 Could	tigation 28e. Place of	Injury - At home, fai	rm, street, f		ing, etc. 2	8f. Location (St	treet and Number or	Rural Route Number, City
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To To with The com	29b. Signature and title of certifier	and manner stated			29c. License nu	ımber		29d. Date signed (Month, Day, Year)
4/	30. Name and address of person Donna M. Vincenti, MD			900 W			ore MD 212	March 26, 201	
State Registrar	Donna M. Vincenti, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 31. Date filed (Month, Day, Year), MAR 2 7 2012 32. Registrar's Signature Street, Baltimore, MD 21223								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Ma		epartment of		d Mental Hy	giene		
			Registrar		ertificate of	Death		Reg. No. 2	2 09395	
П	Physicia Media		Decedent's Name (First, Middle, Last) CHARLES I. CARROLL				2. Date of De March 23		3. Time of Death 0106 A M	
-	Examir		4a. Facility Name (if not institution, give street and number)		4b. City, Town, o	or Location of De	ath	4c. County of Death		
wet.	-	И	7931 ELVATON RD.		GLEN BU	JRNIE		ANNE ARU	NDEL	
	Funeral		5. Social Security Number 219.28.4365 6. Sex 7. Age	(In yrs. last birthda	Months Days	If Under 24 H Hours M			Birthplace (State or Foreign Country)	
	Director		Usual Residence of Decedent	70 Yrs			JULY 21,		MD	
	and shov	힏		10c. City, Town or	Location				10d. Inside City Limits	
	Mary 28a-f otifie	Funeral Director	MD ANNE ARUNDEL	GLEN BURN	IE				1 ☐ Yes 🏋 No	
	h the	무	10e. Street and Number		10f. Zip Code			10g. Citizen of What (Country?	
	th wit ms 23 must	ner	7931 ELVATON RD.		21061			USA		
	r deal or iter iner		11. Marital Status 1 Never Married 2 Married 12. Was Decedent Event Forces? 1 Yes 2 Never Married 2 Narried 12. Was Decedent Event Forces?	er in U.S.	Was Decedent of H If Yes, specify Cub.	lispanic Origin? (an, Mexican, Pue	(Specify Yes or No- erto Rican, etc.)	14. Race - Am Black, Wh		
980	s afte al", c Exam	d by	3 Widowed 4 □ Divorced If Yes, Give Year or Dates.	lo	1 🗆 Yes 2XX No	Specify:		Specify: WHI		
21215-0036	hour natur lical	Completed	15. Decedent's Education		cedent's Usual Occup			16b. Kind of Busines		
21	iin 72 ie. han "	dmo	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+	life	ve kind of work done DO NOT use retired	during most of w	rorking	Too. Tana of Education	o, maddity	
7	d with lygier ther t	Be C	12		POSTAL INSPE	CTOR		USPS		
Maryland	ntal Fied of sed of seven	To B	17. Father's Name (First, Middle, Last)				lame (First, Middle,	Maiden Surname)		
2	ould bud Me	ľ	CHARLES WILSON CARROLL 19a. Informant's Name/Relationship (Type, Print)	1401.14			. WHISTLER			
Z	1 and 2 should be filed within 72 hours after death with the Maryland of Heath and Mental Hygiene. The teath and Mental Hygiene. The marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	, II	MARTHA JEAN DEHNE DAUGHTEI		alling Address (Street 4 MILLER CR.			; City or Town, State, Z	Zip Code)	
ē,	of Hear of Hear fitem		20a. Method of Disposition	20b. Place of Dis	sposition (Name of	I	Date Date	20c. Location - City of	or Town. State	
E	Page 1 nent of ant: If it ury or o		1 ☐ Burial 2 XX Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		rematory or other place REMATORY INC		23,2012	BALTIMORE,		
Baltimore,	permit. Page Department of Important: If any injury or once,		21. Signatur Huner Service Livers e		22 Name and Addre	i		,		
<u> </u>	8 9 E 8 9		K CRECORY FINK	M01148	426 CRAIN HW	Y SW GLEN	BURNIE, MD			
			23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line.	he death. Do not e	enter the mode of dyin	g, such as cardi	ac or respiratory arm	est,	Approximate Interval Between	
P	hysician	250	Immediate Cause (Final disease or condition	tage len	al Diseasi	۷			Onset and Death	
	Medical Examiner		resulting in death) Due to (or as a continuous)	conse-uence of):				-		
		Jer	Sequentially list conditions, b.	ວກເຮືອຊຸດອາເວືອ ປາໂງ.						
	ted Insit	Examiner	cause. Enter Underlying Cause (Disease or injury	, sinosquorios 51).						
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Box	the death by the atter	Physician/Me	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at ti 9 ☐ Unknown 9 ☐ Unknown	me of death 5	Other (specify)			Month	Day Year	
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Sec 3	ite ha	mo					autops perfor	med? death?		
a	ertifica ctor, p		25. Was case referred to medical examiner?		26. Pl	ace of Death (Ch	1 L Yes	2 XX No. 1 L. Ye	s 2 No	
5	his ce	욘	1 Yes 2 No Hospital:	t 2 ☐ ER/Outpat	ient 3 DOA Othe	er: 4 🗌 Nursing	Home 5 Reside	ence 6 🗆 Other (Spec	cify)	
ָם פוניים	Ingra	Certificate	27. Manner of Death 1 ★ Natural 5 □ Pending (Month, Day, Y	/ear) 28b. Time injury	work	at ?		w injury occurred		
	death death stor: ,	‡	2 Accident Investigation 3 Suicide 6 Could not be	A4 h		Yes 2 No				
DIVISION OF	after Direction by	Se	4 ☐ Homicide determined 28e. Place of Injury building, etc. (street, factory, office		28f. Location (St City or Town	reet and Number or Ru , State)	ıral Route Number,	
T Series	within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	Medical	29a. Certifier 1XX Certifying Physician: To the best of my	/ knowledge, deat	h occurred at the time	, date and place	, and due to the car	ise(s) and manner as e	tated.	
of Ho	in 24 he Fu	Med	(Check 2 Medical Examiner: On the basis of examiner only one) 3 Certifying Nurse Practitioner: To the basis of examiners.	nination and/or inv	estigation. In my opinic	n death occurrer	at the time date an	d place and due to the	cause(s) and manner stated	
- E	Vith Com		29b. Signature and title of certifier	-	29c. License			9d. Date signed (Mont		
				MD		50108		3 23	2012	
	L I		30. Name and address of person who completed cause of deat		1 . 1 .	· ·	. / 1	0 1		
	01		Minar Downing 7845	Oakwas	a houd 5	١١٤ ٢٥١	o blev	· Burnie 1	MO 51061	
	State Registra	e r	31. Date filed (Month, Pay Year) 7 2012 32. egistrar's	Signature	bow !			(
		Ţ.,	No.	- 14. 14	Wille					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 09396 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month 03 0956 M Physician/ CLOE ESA 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign
Country) 7. Age (In yrs. last birthday) 8. Date of Birth Social Security Number **Funeral** Hours Min (Month, Day, Year) 214-80-8799 51 Director 1 □ M 2 🕱 F Nov. 17, 1960 Washington, D.C Usual Residence of Deced 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director notified 28a-f 1 Yes 2 X No Davidsonville MD Anne Arundel 10f, Zip Code 10e. Street and Numbe 10g. Citizen of What Country? ō items 23a or ner must be n Funeral 21035 USA 1300 Double Gate Ct. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, ıral", or item Examiner r 11. Marital Status Black, White, etc. þ 1 Yes 2 X No
If Yes, Give
Year or Dates. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 permit, Page 1 and 2 should be filed within 72 hours after 1 Yes 2 X No Specify. White Specify: "natural" Completed 3 Widowed 4 X Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working (Specify only highest grade completed) Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Retail Manager Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) alth and Mental H
27 is marked of
r traumatic even 2 Mary Dolores Smith Jack R. Cloey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) it of Health a: 1300 Double Gate Ct., Davidsonville, MD Mary D. Cloey / Mother other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 9 Department of Important: If any injury or once. Fort Lincoln Cemetery Brentwood, MD 3-30-2012 4 Donation 5 Other (Specify) 22. Name and Address of Facility Beall Funeral Home 21. Signature of Edneral Service Licensee NW Crain Hwy., Bowie,MD 23a. Part 1. Enter the disease, or complice shock, or heart failure. List only one ions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, use on each line. Approximate Interval Between Immediate Cause (Final CIRRHOSIS Onset and Death Ph_sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine Clay to for as a consecuence of tany, leading to in mediate cause. Enter Underlying Cause (Disease or injury that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Pregnant at time of death Unknown Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medica 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 - No ၉ 1 Impatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certi-

Registrar

State

DEFENSE Hwy

NNAPOLISMOZIYOI

Name and address of person who completed cause of death (Item 23a) (Type, Print)

MICHAEL
31. Date filed (Month, Day, Year)

MAR 2

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEND ITEM#20b, perFH, G925, 3/27/2012, WS

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ MARCH 5:03 A M MARYLOU **CUNN I NGHAM** 2012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4c. County of Death PRINCE GEORGES DOCTORS COMMUNITY HOSPITAL LAHNAM 7. Age (In yrs. last birthday If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign 174.22.6003 Min. Hours Country) Director 1 M 2 F 88 12.4.1923 Usual Residence of Dece AL 28a-f show 10a. State 10b County 10c. City, Town or Location notified at 10d. Inside City Limits Director MD 1 Yes 2XX No PRINCE GEORGES **CREENBELT** 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? must be 23a Funeral 7501 MANDAN RD APT 204 20770 IISA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Force XX 11. Marital Status 14. Race - American Indian, other traumatic event, the Medical Examiner Black, White, etc. 0 þ 1 Never Married 2 Married Yes 2 No Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: unninghan, Naryloy "natural", Completed 3XX Widowed 4 ☐ Divorced Specify: **BLACK** Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Il Hygiene. other than " Elementary/Secondary (0-12) College (1-4 or 5+) WAITRESS RESTAURANT Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental h ပ္ **ELISHA BRYANT ELIZABETH** 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Important: If item 27 in any injury or other tra LESLIE JACKSON 7501 MANDAN RD. APT 204 GREENBELT, MD 20770 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 3-31-2012 1 Burial 2 ☐ Cremation 3 Removal from State 4 Donation 5 Other (Specify) **ALLEGHENY CEMETERY** -2012 PITTSBURGH, PA Sign or of Funeral Service 22 Name and aggress of Facility FINK PUNERAL 426 CRAIN HWY SWEGLEN BURNIE, MD 21061 K. CRECORY PHIK M01148 23a. Part 1. Enter the diseashock, or heart failure complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between ily one cause on each line Immediate Cause (Final Onset and Death Physician/ DISSECTION 40 RTIC disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** HYPERTENSION Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of physician and strans that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical P.O. Box 68760 attending physical at the second IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Month Pregnant at time of death Day Year Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş Division of Vital Records, To the Hospital or Attending Physician: The law requires Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy certificate 2 🗌 No 1 Tes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 2 No Other: 1 Yes ပ္ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at after death. Director: After 28d. Describe how injury occurred 5 Pending injury work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be þ 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) within 24 hours a

To the Funeral C

completely filled Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) PHYSICIAN HOUSEOFFICER D0064533 125/2012 2434 W. BELVEDERE 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5 MD BABATUNDE AJANI BATIMORE MD 21215

DHMH 17 Rev 06-2011

State Registrar 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Carolyn (ales March 24 Medical 100 A 4a. Facility Name (if not institution, give street and number) Examiner 4h City Town or Location of Death 4c. County of Death
Baltimore Seasons Hospice Randallstown 5. Social Security Number **Funeral** . Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 216.34.397 Days Hours Director 1 □ M 2 🔀 F 75 12-3-1936 MD Usual Residence of Decedent 28a-f show 10a. State 10b. County at 10c. City, Town or Location Director 10d. Inside City Limits notified MD Howard Columbia 1 ☐ Yes 2 🕅 No 9 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Examiner must be 23a Funeral 21044 5490 Cedar Lane, Unit B1 items death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give ō ò Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 hours after 1 ☐ Yes 2 🂢 No Specify. "natural", Specify: African-American Completed 3 - Widowed 4 Divorced Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) 72 and Mental Hygiene. is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) the Technician Northrop Gruman Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Department of Health and Men Important: If item 27 is marke any injury or other traumatic Norman J. Edwards Hilda E. Truxon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sean A. Cates/Son 5490 Cedar LAne, Unit Bl., Columbia, MD 21044 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory 3-26-2012 Baltimore, MD 21. Signature of Funeral Service Licer 22. Name and Address of Facility Wile Funeral Home P.A. of Faltimore Co. 9200 Liberty Road, Randallstown, MD 21133 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line terval Between Immediate Cause (Final Physician/ Onset and Death Multiple Myeloma disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine Due to (or as a consequence of) if any, leading to immediate Cause (Disease or injury that initiated events and resulting in death) Last Due to (or as a consequence of) attending physician for use as the buria Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery Month Day Year 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has le 2 performed Director: After this certificate of in by the funeral director, pag 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) P 1 ☐ Yes 2 ☑ No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred Natural 5 Pending injury ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours after d

To the Funeral Direct
completely filled in by 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated title of certifier MMD

Registrar DHMH 17 Rev 06-2011

State

29b. Signature and title

31. Date filed (Month, Day, Year)
NAR 2 7 2012

NSRajapalcseMD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5832

Smith N 5203

32. Registrar's Signature

29d. Date signed (Month. Dav. Year) 3124/12

Balamore MD 21709

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State of Maryland / Department of Health and Mental Hygiene 1 - State											
			Registrar 1. Decedent's Name (First, Middle, La	st)	001	tinoate or E	Catri		2. Date of Dea		3. Time of Death			
	Physicia Medio			Paul Fletch	er Crump				March	20	2012	2 9:54 р м		
	Examin	er	4a. Facility Name (if not institution, give Southern Maryland Ho	·		4b. City, Town, or	Location of Clinto					ounty of Death Prince George's		
	Funeral		5. Social Security Number 6. S	Sex 7. Age	(In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hours		8. Date of Birt	h // Yearl	9. Bir	rthplace (State or Foreign		
	Director		570-29-2950 Usual Residence of Decedent	X M 2 D F	50 _{Yrs.}	Months Bays	Tiodio		(MO)3/07	/1962		California		
	yland f shov ed at	tor	10a. State 10b. County		10c. City, Town or Loc							10d. Inside City Limits		
	r 28a- notifie	Direc	MD Prince	George's		10f. Zip Code	Forestvi	ille		10a Cit	1 Yes 2 □ No zen of What Country?			
	with the s 23a c ust be	Funeral Director	7420 Marlboro Pike			10.1 2.10 0000	20747	7		rog. Oit	US			
	r items iner m		11. Marital Status 1 □ Never Married 2 ☒ Married	12. Was Decedent Ev Armed Forces? 1. Yes 2 0	ver in U.S. 13. V	Vas Decedent of His Yes, specify Cubar	spanic Origir n, Mexican, I	n? (Speci Puerto Ri	ify Yes or No- ican, etc.)		14. Race - Ame			
Maryland 21215-0036	rs after ral", o Exam	ed by	3 ☐ Widowed 4 ☐ Divorced	1.4 Yes 2 □ N If Yes, Give Year or Dates.	lo Army	☐ Yes 2 🛚 No	Specify:				Specify:	Black		
15-0	72 hour	Completed	15. Decedent's E (Specify only highest gr		(Give A	ent's Usual Occupa	ation uring most o	of working	3	16b. Ki	ind of Business	/Industry		
212	e filed within 72 hours after death with the Maryland tral Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at		Elementary/Secondary (0-12)	College (1-4 or 5+) life. DO	O NOT use retired) Cas	hier					tail		
pu	ital Hyged other event,	To Be	17. Father's Name (First, Middle, Last)				18. Mother	's Name (aiden Surname)			
ıryla	d Mer marke	-	19a. Informant's Name/Relationship (1	Virgil Crump	10b Mailin	a Address (Street a	and Number	Lorena Carter						
	id 2 sho ealth an n 27 is er trau		Angela F. Myrick / Sister 150 Bragg Blvd, Odenton, MD 21113											
Baltimore,	age 1 and 2 nt of Healt t: If item 2 r or other		20a. Method of Disposition 1 ☐ Burial 2 🍎 Cremation 3 ☐	Removal from State	cemetery, crem	ace of Disposition (Name of Date 2 metery, crematory or other place)						r Town, State		
ıltim	permit. Page 1 a Department of F Important: If ite any injury or ot		4 Donation 5 Other (Specify) Chesapeake Crematory 3/23/2012 Beltsvi 21. Signature of Funeral Service Licensee 22. Name and Address of Facility											
B	Depar Impor any in	13 Baltim	ore, MD 21203											
ı			23a. Part 1. Enter the disease, or comshock, or heart failure. List only of Immediate Cause (Final	plications that caused tone cause on each line	the death. Do not ente	r the mode of dying	g, such as ca	ardiac or i	respiratory arm	est,	A = \	Approximate Interval Between Onset and Death		
	Physician/ Medical		disease or condition resulting in death)	a. Due to (or as	nsequence of):	liste	Con	de	o VIXX	wan	Miles	se Unknow		
ممتعد	Examiner	<u>.</u>	Sequentially list conditions,	b	The SCC consequence of):	NSCON					0	lnknow		
	ed	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	a Consequence of): 2006							Malan		
	ificate be executed g physician and as the burial-transit	Exa	that initiated events resulting in death) Last	C. Due to (or as a	consequence of):	quence of):						Unknows Unknows		
200	ate be ohysici the bu	edical		d	Meumonia						Un Kno.			
687	death certificate be executed the attending physician and led for use as the burial-transi		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome o							23d. Date of de	livery		
Вох	ss that the death certificing igned by the attending be detached for use a	Physician/N	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 Live Birth 2 4 Pregnant at 9 Unknown		Cther (specify)	<i>y</i>				Month	Day Year		
P.O.	that the ned by the e detach	by Ph	Part II. Other significant conditions of	contributing to death bu	t not resulting in the u	nderlying cause give	en in Part I.		23e. Did to	bacco u	se contribute to	the cause of death?		
ds, l	requires t been sign should be	ted b							101	es 2[□ No 3 □ P	Probably 4 Gunknown		
Division of Vital Records,	has be	Completed							24a. Was a autop perfor	sy /	24b. Were au prior to death?	topsy findings available completion of cause of		
al Re	ysician: The la is certificate ha director, page		25. Was case referred to medical			26. Pla	ce of Death	(Check o	1 Yes	2 No		s 2 🗆 No		
Vita	hysicia his cer	To Be	examiner? 1 Yes 2 No	Hospital:		Othe	r:			ence 6	Other (Spec	cify)		
n of	ding P th. After t funera	cate:	27. Manner Death 1 Natural 5 Pending 2 Accident Investigatio	28a. Date of injury (Month, Day,		28c. Injury work? M 1 🗆 `		- 1	d. Describe ho	ow injury	occurred			
isio	r Atten er deal rector: by the	Certificate:	2 Accident Investigatio 3 Suicide 6 Could not be 4 Homicide determined	ne -	y - At home, farm, stre		100 2 2 1	-	3f. Location (Si			ral Route Number,		
Ö	pital or					1 44 4								
	To the Hospital or Attending Physician: The law requires within 24 hours after death. To the Funeral Director: After this certificate has been sign completely filled in by the funeral director, page 2 should by	Medical	(Check 2 Dedical Exam	sician: To the best of miner: On the basis of exesse Practitioner. To the	mination and/or investi	igation, in my opinior	n, death occu	urred at th	ne time, date ar	nd place,	and due to the	cause(s) and manner stated.		
	To t with To tt		29b. Signature and little of certifier	Miller		29c. License	number	(/	1	29d. Date	e signed (Monti	h, Day, Year)		
	r		30. Name and address of person who	completed ause of dea	ath (Item 23a) (Type, P	rint)	!)	7	<u> </u>	(un	ch Ll	12012		
4	1		9135 1180	at au	Rd &	it 23	50	Vin	tou M	0	207	32		
	Stat Registra		31. Date filed (Month, Day, Year) NAR 2 7 2012	32. Registrar	s Signature	Sale Control								

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2012 Physician/ Month 10:50 A M S. Cooper March 24 Robert Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Baltimore Ivy Hall Geriatric & Rehab Center Middle River Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. . Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Hours 229-32-6634 1 X M 2 □ F **Director** 81 Kentucky June 7, 1930 Usual Residence of Deceden 10c. City, Town or Location with the Maryland irector 10a. State 10b. County at 10d. Inside City Limits notified 28a-f Md. Baltimore Dundalk 1 Yes 2 X No ō 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? must be Funeral 7609 Charlesmont Road 21222 USA items . Page 1 and 2 should be filed within 72 hours after death virent of Health and Mental Hygiene. Farti fitem 27 is marked other than "natural", or items lury or other traumatic event, the Medical Examiner muliury or other traumatic event, the Medical Examiner mulius or other traumatic event, the Medical Examiner mulius or other traumatic event, the Medical Examiner mulius or other traumatic event, the Medical Examiner mulius or other traumatic event, the Medical Examiner mulius or other traumatic events. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian, ed Forces? Yes 2 No Black, White, etc. by 1 Never Married 2 Married X Yes Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: Specify: White Completed 3 XWidowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Analyst Steel 12 years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Fred Cooper Nettie Wilson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pat Jerome Daughter 8017 8107 Shore Road, Dundalk, Md. 21222 Department of Health Important: If item 27 any injury or other tr 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State March 26, 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place) Baltimore, Maryland Bayview Crematory 2012 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee Connelly Funeral Home of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md. 21222 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Braenin Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Exami الو use as the burial-tran and that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months?
1 ☐ Yes 2 ☐ No Month 5 Other (specify) Day Year Pregnant at time of death signed by the at d be detached for Unknown 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Onknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed page 2 24 hours after death.

Funeral Director: After this certificate Yes funeral director, Be (25. Was case referred to medica 26. Place of Death (Check only one) examiner? Other: မ 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 5 Pending iniury Natural Accident Investigation filled in by the 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 🖵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗆 within 2 To the I only one) 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year)

State Registrar N. BUTTAW

St Ante 308

BALTIMORE MD 2/201

MD

851

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HASKMI

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year 450 Robert Donald Drager A ... M Medical MAR 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death AIR H G ALTH AR YREHAD ilitATION CEA 5. Social Security Number 8. Date of Birth
(Month, Day, Year)
Apr. 29, 1 If Under 1 Year I If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 X M 2 □ F Min. Hours Country Director 205-16-7337 85 1926 Pennsylvania Usual Residence of Decedent show notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 28a-f 1 🗌 Yes 2 🛛 No Maryland Harford Joppa 10e, Street and Number ō 10f. Zip Code ortant; If item 27 is marked other than "natural", or items 23a or injury or other traumatic event, the Medical Examiner must be in 10g. Citizen of What Country? Funeral 204 Contee Ct. 21085 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces? Black, White, etc. 1 Never Married 2X Married þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: 3 Widowed 4 Divorced Specify: Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 4 Illustrator U.S. Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental F ည John Gordon Drager Edith Romaine Hamme 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important; If item 27 is any injury or other trau Elizabeth Drager / Spouse 204 Contee Court, Joppa, Maryland 21085 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Rose Hill Svcs, LLC 3-26-2012 4 Donation 5 Other (Specify) Bel Air, Maryland Signature of Funeral Service Licensee 22. Name and Address of Facility McComas Funeral Home, P.A. DOMACO 1317 Cokesbury Road, Abingdon, Maryland 21009 far 1. Enter the disease, or complications that cause d the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Examin nding physician and use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical requires that the death certificate be Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? for 5 Other (specify) Month Pregnant at time of death Year 2 No To the Funeral Director: After this certificate has been signed by the a completed filled in by the funeral director, page 2 should be detached a I Inknown P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician: The perform 1 🗌 Yes Be 25. Was case referred to medical Division of Vital 26. Place of Death Pheck only one examiner? Hospital Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 1 Natural 28d. Describe how injury occurred 5 Pending injury work? Accident Investigation within 24 hours after deat To the Funeral Director: Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one the 13902 Z 1308Busus Carker Way Edgewol MD State MAR 27 2012 Registrar

DHMH 17 Rev 7/2009

20BER

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 21^{Day} Physician/ Monroe I. Duke 2012 March 4:30 A. M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Victoria Estates Harford County Bel Air 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, March **Funeral** 9. Birthplace (State or Foreign h 12,1918 Missouri 1 🕅 M 2 🗆 F Days Hours 335-01-1885 94 Director Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director Maryland | Harford County Darlington 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 3214 Harmony Church Road 21034 United States 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 X No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc ō þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2X No Specify "natural", Specify: White 3 X Widowed 4 ☐ Divorced Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed with.
Department of Health and Mental Hygiene Important: If item 27 is marked other that any injury or other traumatic entermination. Martin Co. Aeronautical Engineer 5+ Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Unknown Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Paul Duke (Son) 5282 Morning Mist Lane, Alexandria, Virginia 22312 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2X Cremation 3 Removal from State Forest Hill, Maryland Evans Funeral Chapel 03/22/2012 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Evans Funeral Chapel & Cremation Services-BelAir
B Newport Drive, Forest Hill, Maryland 21050 Jean of Lyn Newport Drive, Forest Hill, Maryland 21050 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final MEDPLASH OF THE BLADIA. ₽nysician/ MALIGNANT disease or condition resulting in death) Medical Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence oi). as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: nse 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ 23d. Date of delivery Live Birth 2 Fetal death in the past 12 months?
1 ☐ Yes 2 ☐ No ō Pregnant at time of death Month Day Unknown Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed I 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 🖪 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No 25. Was case referred to medical Be 26. Place of De h (Check only one) examiner? Hospital: 1 🗌 Yes 2 No Other: မ 4 Mursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending s after death. 1 Yes 2 No 2 Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) pleted filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a To the Funeral D To the Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number DOD 16 3 89 29b. Signature areig MARCH 21, 2012 lame and address of person who completed cause of death (Item 23a) (PECFOC. VALAR AD, M.D. address of person who completed cause of death (Item 23a) (Type, Print) 1716 HARFORD ROMP SU-105 FALLSTON HD 21047 31. Date filed (Month, Day, Year)

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 20h per fb 30 per dyr. 9925 3 27-12 Hygiene State of Maryland / Department of Health and Mental Hygiene

			1 - State Registrar	Certificate of Death	Reg.	No. 2012 0940	3								
ı	Physicia	an/	1. Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year 3. Time of Death									
y.2:	Medi Exami			4b. City, Town, or Location of Death		, 2012 10:10 P	<u>M</u>								
750) Lami	iici	7409 McKaig Road	Frederick		4c. County of Death Frederick									
	Funeral Director		5. Social Security Number 6. Sex 7. Age (in yrs. last birt $226-36-4028$ 1 \square M $2X$ F 80	thday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Yrs.											
	yland •f shor ed at	to	10a. State 10b. County 10c. City, Town			10d. Inside City Limits	,								
	r 28a- notifi	Direc	MD Frederick Fre	derick		1 X Yes 2 N	0								
	th with th ms 23a o must be	Funeral Director	7409 McKaig Road	10f. Zip Code 21701	Ţ	Citizen of What Country? Inited States									
9000	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	2	1 Never Married 2 Married 1 Yes 2 No	Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto □ Yes 2 No Specify:	cify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White									
1215-	rithin 72 ho iene. r than "na the Medio	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12.	Decedent's Usual Occupation (Give kind of work done during most of workilife. Do NOT use retired) Homemaker	ng	8b. Kind of Business/Industry Own Home									
Maryland 21215-0036	ild be filed w Mental Hygi harked othe atic event,	To Be	17. Father's Name (First, Middle, Last) George Coburn		e (First, Middle, Maide										
	and 2 shou lealth and em 27 is m		Charles Demmons/ Son 3	Mailing Address (Street and Number or Rura 341 Eclipse Dr. Jeffe											
Baltimore,	it. Page 1 as rtment of H rtant: If ites njury or oth		1 → Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Mount	ry, crematory or other place) Zion Cemeterv 3-23-	Date 20c. Location - City or Town, State Frederick, Maryland										
Bal	permi Depar Impor any in		21. Signature of Funeral Service Licensee MO1646	1. Signature of Funeral Service Licensee 22. Name and Address of Facility Ko											
÷	Physician/ Medical Examiner		23a. Part 1. Enter the disease, or complications that caused the death. Do no shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the con	of enter the mode of dying, such as cardiac o	r respiratory arrest,	Approximate Interval Between									
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00	death certificate be executed he attending physician and led for use as the burial-transit	Medical Exa	that initiated events resulting in death) Last C. Due to (or as a consequence of d	of):											
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Box 6	he death certi y the attendin iched for use	Physician/	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 4 Pregnant at time of death 9 Unknown	3 Ectopic pregnancy 5 Other (specify)		23d. Date of delivery Month Day Year	d								
ds, P.O.	requires that the dea been signed by the a should be detached (Part II. Other significant conditions contributing to death but not resulting in	n the underlying cause given in Part I.		o use contribute to the cause of death? 2 No 3 Probably 4 Unknown	,								
Division of Vital Records,	The law ate has page 2	Completed by	LUNG CANCER		24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No									
ital	Physician: The this certificate are director, pag	Be	25. Was case referred to medical examiner?	26. Place of Death (Check											
of V	S S	e: To	27. Manner of Death 28a. Date of injury 28b. Ti	tpatient 3 LI DOA 4 LI Nursing Hon	ne 5 Residence 8d. Describe how inju		-								
on (Attending or death. Sector: After by the fune	ficat	2 Accident Investigation	ijury work? M 1 ☐ Yes 2 ☐ No	ou. Describe flow inje	ary occurred									
Divisi	ial or Atten s after deat al Director; ed in by the	Certificate:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, far building, etc. (Specify)	m, street, factory, office	28f. Location (Street a City or Town, Stat	and Number or Rural Route Number, (e)									
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, do 2 Medical Examiner: On the basis of examination and/or 3 Certifying Nurse Practitioner: To the best of my know	investigation, in my opinion, death occurred at t	the time, date and place	ce and due to the cause(s) and manner state	∍d.								
	North Con		29b. Signature and title of certifier	29c. License number 1) 6 9 6 8		ate signed (Month, Day, Year)									
			30. Name and address of person who completed cause of death (Item 23a) (T		1 3	120/12	_								
F	01		Austin Pearre 300 W. 9th St. Fre												
1	Stat Registra		31. Date filed (Month, Day, Year) 32. Registration Signature												

Timeof Please Type or Print in Bank Indelible Ink. Ensure All Copies Are State of Maryland Department of Health and Mental Hygiene 09404 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month **Physician** 22, 12:30 AM Carolyn Sargent Discepola March 2012 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Shady Grove Nursing Home Rockville Montgomery If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days 1 □ M 2 N F Director 456-23-3620 51 12/02/1960 Texas Usual Residence of Decedent 10c. City. Town or Location 10a. State 10h County 10d. Inside City Limits ns 23a or 28a-f show must be notified at 1 X Yes 2 No Director MD Montgomery Germantown 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 13648 Spinning Wheel Drive U.S.A. 20874 death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. i "natural", or Items ledical Examiner in Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 Never Married 2K Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify. Specify: þ 3 ☐ Widowed 4 ☐ Divorced White Completed Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) other than ' Elementary/Secondary (0-12) College (1-4or 5+) <u>12</u> Cleaning Crew Supervisor Cleaning 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 27 is marked of traumatic ever ည Adams. Susan Irene Sargent 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Health em 27 i Alexandra Adams / Sister 13648 Spinning Wheel Dr., Germantown, MD 20874 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages
Department of
Important: If it
any Injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) Anataw Gifts Registry 03/26/2012 | Hanover, Maryland 21. Signature of Funeral Service in ensee 22. Name and Address of Facility Anatomy Gifts Registry 7522 Connelley Dr., Ste. P, Hanover, MD 21076 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician arolio pulmonen /Medical Due to (or as a consequence of) Examiner ung COMI Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a const quence of): Examiner The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): physician the burial Division or Vital Records, P.O. Box 68760, Physician/Medical attending ph I for use as the IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 5 Other (specify) ed by the a detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by cate has been sig , page 2 should b 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 1□ Yes 2 No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Hospital: 1 ☐ Inpatient To Other: 1 Yes 2 No 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) funeral di After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 5 Pending investigation 1 Natural Injury after death.

Director: A

in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a Hospital 1 🗆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 70067092 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Shady Gome Rel 1/30, Rockville, unD 20850 wans 15245 lei hom iled (Month, Day, Year) 31. Date 32. Registrar's State 2012 MAR 27 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 09405 State of Maryland / Department of Health and Mental Hygiene ? 1 ? 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Richard Allen DeRita, Jr. Physician/ March 20, 2012 9:00 P Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll Hospital Center Westminster Carroll 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Days Months Hours Min. 212-72-7444 1 X M 2 D F **Director** Yrs 54 11/10/1957 Maryland Usual Residence of Deci 28a-f show 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 and 2 should be filed wittin 72 hours after death with the Maryland if Health and Mentel Hyglere. item 27 is marked other han "natural", or items 23a or 28a-f sho 10a. State must be notified at Director 1 Yes 2 X No PA Adams Littlestown 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 1245 Harney Rd. 17340 United States Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, "natural", or item edical Examiner n 12. Was Decedent Ever in U.S 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 2/215-0036 1 ☐ Yes 2X No Specify: Specify: White 3 Widowed 4X Divorced Completed Year or Dates Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Il Hygiere. I other han 'vent, tre Me Elementary/Secondary (0-12) 12th College (1-4 or 5+) Northeastern Supply Plumbing Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Richard Allen DeRita, Sr. Edith Petry 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edith Naill (Mother) 1245 Harney Rd. Littlestown, PA 17340 injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or ot cemetery, crematory or other place, 1 X Burial 2 Cremation 3 Removal from State Bethany Cemetery 4 Donation 5 Other (Specify) 3/24/2012 New Windsor, Md 22. Name and Address of Facility Signature of Funeral S Burrier-Queen Funeral Home and Crematory, P.A Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardia or respiratory arrest. | MD | 21,784 | Approximate shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events burial-tran Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical requires that the death certificate be Division of Vital Records, P.O. Box 68760 the IF FEMALE: asn yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Pregnant at time of death signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 No has death? within 24 hours after death.

To the Funeral Director: After this certificate I completely filled in by the funeral director, pag To the Hospital or Attending Physician: filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify, 2 No ၀ 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Sign ature and title of cer 29d. Date signed (Month, Day, Year) mo 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Timothy Hsu, MD 200 Memorial Ave. Westminster, MD 21157 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 17 A M THOMAS HAROLD DORSEY 24 2012 Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Wicomico 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth 9. Birthplace (State or Foreign Funeral Months Hours Min. Country) 1 X M 2 - F AUGUST^{Pay}3^Y1^{ar)}1946 217-50-3026 MD 65 Director Usual Residence of Decedent or 28a-f show notified at 10d. Inside City Limits 10b. County 10a, State 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland Director 1 XYes 2 No N/A BALTIMORE 10f. Zip Code items 23a or ner must be n ō 10e. Street and Number 10g. Citizen of What Country? Funeral 21205 USA 4904 WILBUR AVE 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian 11. Marital Status ural", or iter I Examiner I Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. WHITE Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: "natural" 3 Widowed 4 Divorced Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natun any injury or other traumatic event, the Medical once. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) JARVIS STEEL Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) MARY R. KAVEY HAROLD E. DORSEY 19a. Informant's Name/Relationship (Type, Print)
DON DORSEY-BROTHER 19b. Mailing Address (Street and Number of Rural Route Number, City of Town, State, Zip Code)
35071 SUNRISE CT PITTSVILLE, MD 21850 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State PARKWOOD CEMETERY 3/27/12 BALTIMORE, MD 4 ☐ Donation 5 ☐ Othery(Specify) 21. Signature of Funeral Service Lie 22. Name and Address of Facility SCHIMUNEK FUNERAL HOME 9705 BELAIR RD NOTTINGHAM, MD 21236 , or c implications that c issed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, st only one cause on each limited to the death. Part 1 Enter the disease, or cost ock or heart failure. List only Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (o as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): signed by the attending physician and d be detached for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time of death
Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year 5 Other (specify) 9 Unknown Par th? ģ known eted

t II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco us	e contribute to the cause of deat
	1 🗌 Yes 2 🗆	No 3 Probably Uni
	24a. Was an autopsy	24b. Were autopsy findings ava prior to completion of caus

				autopsy performed? 1 Yes 2 No 1 Yes 2 No								
v l	25. Was case referred to medical	26. Place of Death (Check only one)										
	examiner?	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐	Home 5 Residence Other (Specify) HO Spile									
licate.	27. Manuer of Death Natural 5 Pending 2 Accident Investigation	(Month, Day, Year) injury M		28d. Describe how injury occurred (IL GLR								
	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, street, factor building, etc. (Specify)	ory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)								
9	\$ D			1.1.1.1								

. 1													
	29a. Certifier 1 Certifying Physician: To the best of my												
	(Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.												
	only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.												
	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)										

		Δ	1												
30.	Name		ď	ddress	of	person	who	completed	cause	of	death	(Item	23a)	(Туре,	Prin

VOHRA CHORE BR, SAUSBURY MD. 21804

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ONALD 0:12AM 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Howard County General Hospital Columbia Howard 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) Hours (Month, Day, Year) 228-19-1512 Usual Residence of Decede 1 X M 2 🗆 F 48 July 21, 1963| Pennsylvania 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2X No Howard Columbia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5624 Tricross Drive 21045 U.S.A. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status vvas Decedent Ever in U.S. Armed Forces? NXYes 2 No If Yes, Give Year or Dates. Page 10 U.S. Desert Storm 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Tech support Verizon 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Hilda Marie Scheib David Donald Deitrich 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Hilda M. Deitrich - mother 409 N. Kent St., Winchester. VA 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 🗆 Burial 2 💢 Cremation 3 🗆 Removal from State 3-22-12 4 ☐ Donation 5 ☐ Other (Specify) Hebron Cemetery Winchester, VA 21. Signature of Funeral Service Licenses Robert A. Pumphrey Funeral Home, Bethesda—Chevy 7557 Wisconsin Avenue, Bethesda, Maryland 20814 Willian MO1173 23a. Part 1. Enter the disease, or complications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause an each line. Approximate Interval Between Onset and Death Empolisa Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): 1

Priysician/ Medical **Examiner**

Department of Health Important: If item 27 any injury or other tr

Physician/

Medical

10a. State

MD

Examiner

Funeral

Director

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"natural", or items 23a o

ulth and Mental Hygiene. 27 is marked other than "natur r traumatic event, the Medical

Completed by Funeral Director

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permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

the Hospital or Attending Physician: The law requires that the death certificate be executed thin 24 hours after death.

the Funeral Director: After this certificate has been signed by the attending physician and as the burial-trar signed by the at d be detached for director, page 2 within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral of

Division of Vital Records, P.O. Box 68760

Medical Certificate: To Be Completed by Physician/Medical Examiner

29b. Signature and title of certifier

31. Date filed (Month, Day, Yea,

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of): C. Due to (or as a consequence of): d		
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregnancy 1		23d. Date of delivery Month Day Year
Part II. Other significant conditions	ontributing to death but not resulting in the underlying cause given in Part I.		o use contribute to the cause of death? 2 □ No 3 □ Probably 4 □ Unknown
		24a. Was an autopsy performed 1	
25. Was case referred to medical examiner?	26. Place of Death (Che	eck only one)	
1 Yes 2 No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing	Home 5 Residence	6 ☐ Other (Specify)
27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be		28d. Describe how inj	ury occurred
4 Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street a City or Town, Sta	and Number or Rural Route Number, ite)
(Check 2 Medical Examin	ician: To the best of my knowledge, death occurred at the time, date and place ner: On the basis of examination and/or investigation, in my opinion, death occurred e Practitioner: To the best of my knowledge, death occurred at the time, date and	at the time, date and pla	ice, and due to the cause(s) and manner state

29c. License number

29d. Date signed (Month, Day, Year)

21201.

DHMH 17 Rev 06-2011

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 1 - For State Registrar Certificate of Death Reg. No Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month ELBECK 2012 11:28 AM C **Medical** 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTI RE SECOURS HOSP, IAL MO If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Funeral Months Hours Maryland 216-62-6413 55 Director _15 Usual Residence of Decedent 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State the Maryland Director notified Baltimore Maryland 1X Yes 2 ☐ No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? ō must be 23a Funeral 21217 1217 N.Calhoun Street USA items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Examiner Armed Forces?

1 Yes 2 No ö 1 Never Married 2 Married by Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates Specify: Black "natural", 3 Widowed 4 Divorced Completed permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natul any injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Baltimore City Elementary/Seconday (0-12) College (1-4 or 5+) Housing Authority Secretary <u>12th grade</u> years Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Sterling Elbeck Alice Thornton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9823 Charbank Lane Baltimore, Md. 21220 Tieria Carter/Daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 🛣 Burial 2 □ Cremation 3 □ Removal from State 03-31-12 Woodlawn, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Cemeterv 22. Name and Address of Facility Chatman-Harris Funeral Home 21. Signatur Funeral Service Licenses 5240 Reisterstown Rd.Baltimore, Md. 21215 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final REBROVASCULAR Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Exami Cause (Disease or iinjury that initiated events resulting in death) Last and-tran Due to (or as a consequence of) attending physician at for use as the burial-Physician/Medical certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Other (specify) signed by the signed be detached f Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy 1 Yes 2 No ospital or Attending Physician: 'hours after death. neral Director: After this certific: 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? Other: 1 Tes 2 No ᅙ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred (Month, Day, Year) iniury 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation filled in by the Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) within 24 hours a

To the Funeral C

completed filled Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 🗆 only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Ta and address of person who completed cause of death (Item 23a) (Type, Print) SECOURS D 32. Registrar's Si State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ March 26, Day 2012 5:00 A M Eller Warren G. Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Harford Heart Heritage Assisted Living Forest Hill Social Security Numbe 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country)
North Carolina **Funeral** 8. Date of Birth May 9, 1921 1**X** M 2 □ F 90 Days Months Hours **Director** 220-22-0327 Usual Residence of Decedent 28a-f show 10a. State 10b. County with the Maryland event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland Harford Forest Hill 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 1903 Medallion Court 21050 USA or items 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify. "natural", 3 X Widowed 4 □ Divorced Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working and Mental Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 9 Bus Driver U.S. Government it. Page 1 and 2 should be filed w rtment of Health and Mental Hygi rtant: If item 27 is marked othe njury or other traumatic event, I Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 2 Benjamin Harrison Eller Leona (unk) Minton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Warren T. Eller / Son 1903 Medallion Court, Forest Hill, Maryland 21050 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a
Department of H
Important; If ite
any injury or ott 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, 4 ☐ Donation 5 ☐ Other (Specify) Bel Air Memorial Gdn. 2/29/2012 Bel Air, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final OBStructive Onset and Death CIHONIL Pnysician/ u/monny disease or condition 40 Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to in necleate cause. Enter Underlying Due to for as a consequence of: Exam Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last the burial-tran and Due to (or as a consequence of): signed by the attending physician d be detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death Month Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has page 2 autopsy performe 2 No Yes 2- N : After this certifications of the funeral director, I 25. Was case referred to redical Be 26. Place of Death (Check only one) examiner? 2 No Other: မှ 1 Tes 1 Inpatient 2 ER/Outpatient 3 I DOA 4 ☐ Nursing Home 5 ☐ Residence 6 😾 Other (Specify) Assisted Certificate: 27. Mann of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Living Natural 5 Pending 1 Yes 2 No Accident
Suicide 24 hours after death Funeral Director: the Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, dearn occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the within 2 To the F only one)

Registrar

DHMH 17 Rev 7/2009

State

29b. Signature and title of certifier

31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

62. Registrar's Signature

LGRAP SPARIUS

MARCH 26, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Elsroad Month Be Hy 9:280 M meuron 7013 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 180 Ritchie Hwy., Apt. 101 Severna Park Anne Arundel 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Director 212-30-0193 1 🗆 M 2 🔀 F 79 Yrs. Nov. 07 1932 MD show 10b. County ral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 😾 No Maryland Anne Arundel Severna Park 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 180 Ritchie Hwy., Apt. 101 21146 USA death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian. Armed Forces Black, White, etc. 1 Never Married 2 X Married à Yes 2 X No hours after Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: If Yes, Give "natural", Specify: White 3 Widowed 4 Divorced Completed Year or Dates event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) 72 than, Elementary/Secondary (0-12) College (1-4 or 5+) Household Homemaker 12 is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Calvin Musgrove Estelle Greene 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s if Health item 27 180 Ritchie Hwy., Apt. 101, Wilbert J. Elsroad Jr. (spouse) Severna Park, MD 21146 other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
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Important: If ite
any injury or ott March X Burial 2 Cremation 3 Removal from State Toudon Park Cemetery 4 Donation 5 Other (Specify) Baltimore, Maryland 2012 21. Signature of Funeral Service Lie nsee 22. Name and Address of Facility Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 21122 ve death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line Approximate Interval Between Onset and Death Immediate Cause (Final Physician Pancreatic Cancer disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Exami and Due to (or as a consequence of): resulting in death) Last attending physician for use as the buris Physician/Medical certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Day Month Year Pregnant at time of death Unknown 1 Yes 2 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Completed 2. No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has autopsy performed? Yes 2 N death? Hospital or Attending Physician: 7 24 hours after death. Funeral Director: After this certifica 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? ျ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending injury 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hor

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completely fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier

MS Ray Apathl MD 29d. Date signed (Month, Day, Year) 00057465 3124/12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore MD 21709 NS Rajapaksemo 2835 Smin AV Date filed (Month, MAR 2 Registrar

DHMH 17 Rev 06-2011

Registrar

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Baltimore, Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Memtal Hygiene. Important: If field 71 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, it is fielded Examines must be notified at once.		21. Signature of Funeral Service Licen	see		22 R 9	Name and Address app Fune: 33 Gist	raf Facili Raf a	ind Ci	cematio	on S	Servic		910	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 U State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 03 9:00 AM LORRAINE FRIESON 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner RICHMOND AVENUE BAUTIMORE If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) ial Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 214-40-0354 Director 1 M 2 XF 67 05-18-1944 SC "natural", or items 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at Completed by Funeral Director MD BAUTIMORE 1X Yes 2 ☐ No 10e. Street and Number 10g. Citizen of What Country? 1505 DAKRIDGE 21218 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) . Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Black, White, etc. 1 XNever Married 2 Married 1 Yes If Yes, Give 2 No Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: BLACK 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) PUBLIC College (1-4 or 5+) Elementary/Secondary (0-12) SCHOOL SYSTEM TEACHER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, BAKER FRIESON MINNIE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) GLENWOOD AVE. BALTO, MD. 21239 FRIESON (BrOTHER) WILLIAM Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
PARKWOOD CEMETERY Date Method of Disposition 1 Burial 2 Cremation 3 Removal from State 3/29/2012 BATIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility VAUGHN GREENE FUNERAL SCUS 4905 YORK ROAD. BALTO, MD. 21212 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) Physician/ 20 V Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to for as a consequence of Cause (Disease or injury To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregn 23d. Date of delivery 3 Ectopic pregnancy in the past 12 mont Month 5 Other (specify) Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy within 24 hours after death.

To the Funeral Director: After this certificate Yes 25. Was case referred to dica 26. Place of Death (Check only one) Medical Certificate: To Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Sisters Hause 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Mann of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending work?
1 Yes 2 No Accident
Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Registrar's Signature State Registrar

Frieson

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of M	-	partment of F			giene ()	12 09414		
	Physici	an	Decedent's Name (First, Middle	American S.	011			2. Date of Dea Month	Day	Year 3. Time of Death		
	/Medic	al	4a. Facility Name (If not institution			4b. City, Town, o	r Location of De	eath	4c. County	of Death		
	Examin	er	Future Care Co		,	Baltimo			Batti			
	Funeral		5. Social Security Number	6. Sex 7. A	ige (In yrs. last birtho	Months Days	If Under 24 I	Hrs. 8. Date of Birt	ate of Birth fonth, Day, Year) / 25/1936 9. Birthplace (State or Country) OH			
	Director		291304134	1 □ M 2 🖫	7.5 Yrs	S. Moritis Days	Tiodis	08/25/	1936	ОН		
	and	}	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town o	r Location				10d. Inside City Limits		
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	r 28a	<u>re</u> c	10e. Street and Number	<u>es</u>	UKEECI	10f. Zip Code			10g. Citizen of V	Vhat Country?		
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	r dea	ner	11. Marital Status	12. Was Deceder Armed Forces		 Was Decedent of H If Yes, specify Cuba 	lispanic Origin? an, Mexican, Pi	? (Specify Yes or No- uerto Rican, etc.)	- 14. Raci Blac	e - American Indian, k, White, etc.		
36	s afte	by Fi	1 ☐ Never Married 2 ☐ Marr 3 🛣 Widowed 4 ☐ Divorced	ied 1 ☐ Yes 2 🖔 If Yes, Give Year or Dates		1 ☐ Yes 2¥É No	Specify:		Specify	White		
21215-0036	72 hours after death with the Marylan neturel; or Items 23a or 28a-1 show iteal Examinet must be notified at	ted t	15. Decedent	's Education	16a. D	ecedent's Usual Occup	ation		16b. Kind of Bu	usiness/Industry		
215	hin 7.	Completed	(Specify only highes Elementary/Secondary (0-12)	completed) College (1-4o	-//	Give kind of work done fe. DO NOT use retired	during most of d)	working				
2	filed within 72 hours after death with the Maryland Hygiene. ther then "neturel", or flems 23a or 28a-f show wit, the Madical Examiner must be notified at	Con	12		Ins	tructor	40.14.15.1	N		nt Loss		
and	be fill ad off	Be	17. Father's Name (First, Middle,	Henrv	N	IcCo y		Name (First, Middle,				
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	and 2 sealth an n 27 ls		Brenda Finne			07 White						
re,	of Health item 27		20a. Method of Disposition		20b. Place of D	isposition (Name of crematory or other place	ce)	Date	20c. Location -	City or Town, State		
<u>ii</u>	Page ment c		1 Burial 2 Cremation 3 XRemoval from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee Ortona Cemetery 03/27/12 Ortona, 22. Name and Address of Facility Leonard J. Ruck,									
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hr Department of Health and Mental Hyglene. Importent: if item 27 is marked other then "netu any injury or other traumatic event, the M-sical QDCE.		21. Signature of Funeral Service	Licensee								
	20280		23a. Part1. Enter the disease, or	complications that caus	ed the death. Do no	5305 Har				Approximate		
			shock, or heart failure. List Immediate Cause (Final	only one cause on each	line.	Cancer	19, 000, 00			Interval Between Onset and Death		
7	Physician /Medical		disease or condition resulting in death)	a Due to (or a	as a consequence of	Canac						
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	p tis	iner	Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to lor a	as a consequence of							
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Вох	eath certificat attending phy I for use as th	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcon 1 ☐ Live birth	ne of pregnancy 2 Fetal death	3 ☐Ectopic pregnanc	у			te of delivery onth Day Year		
O. E	he dea the att	Physiclan/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant 9□Unknown	at time of death	5 ☐ Other (specify) _			1010	Milli Day Fear		
<u>α</u>	The law requires that the death certifica tte has been signed by the attending ph page 2 should be detached for use as if	Phy	Part II. Other significant condition	ons contributing to death	but not resulting in t	ne underlying cause giv	ven in Part I.	23e. Did t	obacco use cont	ribute to the cause of death?		
Records,	uires l signe	d by						1	Yes 2□No	3 Probably 4 Dunknown		
SO	w requires been si	Completed						24a. Was		Were autopsy findings available		
Re	sicien: The law s certificate has b irector, page 2 s	ошб						— autor perfo	ormed3/	prior to completion of cause of death? 1 ☐ Yes 2 ☐ No		
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of V	Physicien: this certific ral director,	ို	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Uther Nursing Home 5 Residence 6 Other (Specify)									
o uc		27. Manne of Death 1										
Division	or Attending after death. Director: After in by the fune	ficat	3 Suicide 6 Could	not be 28e. Place of	Injury - At home, farn	, street, factory, office	1100 2 0110	28f. Location (Street and Numb	per or Rural Route Number,		
Ο̈́	al or A s after I Dire	Serti	4 Homicide	building,	etc. (Specify)	,		City or To	wn, State)			
	ospit hours unera ly fille	cal		ng Physician: To the be Examiner: On the basis								
	To the Hospitel or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Aedi	one)	and manner		29c. Licens				ed (Month, Dey, Year)		
	To To	6	29b. Signature and title of certifie	(A D								
7			30. Name and address of person	who completed cause of	f death (Item 23a) /T	vne Print)	767	, ,	- 1 2	7 1 1 -		
			Now All	Chara	5 8	ype, Print) 813 Wall	Man	Wood,	Lass 1	(.MD 21234		
	Sta	ate	31. Date filed (Month, Day, Year)	82. Regi	strar's Signature		1- "	<u>, </u>		· · · · · · · · · · · · · · · · · · ·		
	Regist	rar	MAR 2 7 20	112 Senson	1 B. M.	we						

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. ? 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ MARCH 24 2012 04:45P M FRIEDMAN ARNOLD Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** MONTGOMERY CASEY HOUSE ROCKVILLE . Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Months Days Hours Min Director 129-22-1662 1 🛛 M 2 🗆 F 94 11/02/1917 NY Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Director notified 1 Yes 2 X No FI. PALM BEACH DELRAY BEACH 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? ō ms 23a or must be Funeral 14426 AMBERLY LANE, #306 33446 USA items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian rmed Forces?

X Yes 2 No Black, White, etc. Ь þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. If Yes, Give Year or Dates Specify: "natural" Completed 3 X Widowed 4 Divorced WHITE Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working r than " life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) OWNER KOSHER MEAT MARKET ed other event, th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ith and Mental F 27 is marked of traumatic ever 2 FRIEDMAN MORRIS JENNIE HYMOWITZ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau once. BARBARA ANGRES / DAUGHTER 6 WAR ADMIRAL COURT, GAITHERSBURG, MD 20870 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cametery scenatory of other place) ETERNAL LIGHT MEMORIAL GARDENS 1 X Burial 2 Cremation 3 X Removal from State 4 Donation 5 Other (Specify) 03/25/2012 BOYNTON BEACH, FL 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or compli-shock, or heart failure. List only one cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final .Ph. sician/ MULTIPLE MYELOMA disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) burial-transi Cause (Disease or injury that initiated events resulting in death) Last and Due to (or as a consequence of) physician Physician/Medical Hospital or Attending Physician; The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the use as iding IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? for 5 Other (specify) Month Dav Year Pregnant at time of death the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by been signer should be c 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 \(\subseteq \text{Yes} \) 2 \(\subseteq \text{No} \) 24a, Was an sate has l autopsy performed?

1 Yes 2 X No 25. Was case referred to medical funeral director. 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 X Other (Specify) HOSPICE 1 Yes 2 X No မ 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 5 Pending injury 1 X Natural s after death. Investigation Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined 24 hours a Funeral C Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hor To the Fune completely f

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State Registrar (Check

29b. Signati

only one

e and the of certif

Debra Miller 31. Date filed (Month, Day, Year,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Casey House

Rockvile, Maryland

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. The critiquing Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

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29d. Date signed (Month. Day, Year) 24

29c. License numbe

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ arv MARCH 2012 09:33AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE REISTERSTOWN 334 TIMBER GROVE ROAD If Under 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Hours Min. (Month, Day, Year) Country) Director 126-24-8410 1 🛚 M 2 🗆 F 88 02/03/1924 **GERMANY** Usual Residence of Decedent show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location the Maryland Director must be notified 28a-f 1 Yes 2 X No BALTIMORE REISTERSTOWN MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Numbe ö 23a Funeral with 334 TIMBER GROVE ROAD 21136 USA items death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 2 X No Examiner Black, White, etc. ō 1 Never Married 2 Married þ permit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. 1 Yes 2 No Specify: Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates "natural" Completed 3 Widowed 4 Divorced WHITE er than "natur the Medical B 16a. Decedent's Usual Occupation (Give kind of work done during most of working Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) life, DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4 or 5+) MENS CLOTHING DESIGNER nt of Health and Mental Hygie t: If item 27 is marked other or other traumatic event, the Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ COOPER **GAER** GITA ARNOLD 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 334 TIMBER GROVE ROAD, REISTERSTOWN, MD 21136 VICTORIA GAER/WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Department of H Important: If ite any injury or oth once. 1 X Burial 2 Cremation 3 Removal from State MOSES MONTEFIORE 03/25/2012 BALTIMORE, MD 4 Donation 5 Other (Specify) Signature of Funeral S SOL LEVINSON & BROS., INC. 22. Name and Address of Facility chall 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, cause on each line. 23a. Part 1. Enter the disease, or composhock, or heart failure. List only on Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ neumon disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** chi Sequentially list conditions Examine if any, reading to immediate cause. Enter Underlying USTENDUTOS executed Cause (Disease or injury that initiated events burial-tran and Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the use as attending IF FEMALE 23c. If yes, outcome of pregnancy
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To the Funeral Direct

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DHMH 17 Rev 06-2011

State

Registrar

30. Name and address of

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erson who completed cause of death (Item 23a) (Type, Print)

32. Registrar's

rechetee

7 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2012 Physician/ 12:00 PM March 24, Josiah Alexander Gibson Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Catonsville Charlestown Care Center If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Social Security Number 9. Birthplace (State or Foreign Funeral 7. Age (In yrs. last birthday) Hours 1 ☑ M 2 ☐ F 6478 1923 Sept. Director 012-14-7729 88 Usual Residence of Decedent 28a-f shov 10a. State 10c. City, Town or Location 10d, Inside City Limits Examiner must be notified at Director Baltimore Catonsville 1 ☐ Yes 2 🛣 No 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral USA 707 Maiden Choice Lane Apt 8T01 21228 items 12. Was Decedent Ever in U.S. Armed Forces?

1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates. 1942-47 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. White "natural", or ģ 1 Never Married 2 Married 72 hours after 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify 3 Widowed 4 Divorced Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working (Give Killa of Work Golffeet Campy Interesting)
Vice President
Industrial Relations al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Dredging permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked other any injury or other traumatic event, I Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٩ Bertha McKinley George C. Gibson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 707 Maiden Choice Lane Apt 8T01; Catonsville, MD 21228 Evelyn Gibson Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 3/26/2012 Glen Burnie, MD 4 Donation 5 Other (Specify) Atlantic Crematory 22. Name and Address of Facility Sterling Ashton Schwab Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue, Catonsville, M MD 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betweer Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, it any leading to immediate cause. Enter Underlying Due to or as a consquence of Exami Cause (Disease or iinjury that initiated events resulting in death) Last trar Due to (or as a consequence of): attending physician for use as the buria Physician/Medical that the death certificate be Division of Vital Records, P.O. Box 68760 the IF FEMALE: 23c. If yes, outcome of pregnancy
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1 ☐ Yes 2 ☐ No Day Year Month the signed by the detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ or Attending Physician: The law requires 2 No 3 □ Probably 4 □ Unknown 1 Yes Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a, Was an autopsy performed? Yes 2 No page 2 s has 24 hours after death. Funeral Director, After this certificate 25. Was case referred to medica 26. Place of Death (Check only one) director, Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ဂ္ဂ 28a. Date of injury (Month, Day, Year) funeral 28b. Time of 27. Manner of Death 28d. Describe how injury occurred Certificate: 28c. Injury at work? injury 1 Natural 5 Pending work? 2 🗆 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by determined City or Town, State) Hospital Medical terifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one 3 [29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 7/2009

State Registrar

120

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signat

CL 469

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Physician/ 0520 AM MARCH Garvey 2012 J. John . Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SAIN AGNES HOSPITAL BALTIMORE If Under 1 Year If Under 24 Hrs. Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Min. Days 1 X M 2 □ F Months Hours March Pay9 (ear) 1925 Mary Tand 87 219-18-4950 Director Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1X Yes 2 No Baltimore Maryland 10e. Street and Number 10f. Zip Code 10g Citizen of What Country? 5 and Mental Hygiene. is marked other than "natural", or items 23a or aumatic event, the Medical Examiner must be r Funeral 21201 USA 524 N. Charles St., Apt 1200 death v Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?
1 X Yes 2 □ No þ 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 72 hours after 1 Yes 2X No Specify: If Yes, Give Year or Dates. 43-45 Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) State of Maryland Officer Personnel Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) ၉ be Ruth Beneze Joseph M. Garvey, Sr. t. Page 1 and 2 should by thent of Health and Mer tant: If item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 600 Oak Hill Rd., Catonsville, Maryland 21228 Mary Ruth Buchness- sister other i 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of H Important: If ite any injury or ot once, 1 XBurial 2 Cremation 3 Removal from State 3/26/2012 Baltimore, Maryland 4 Donation 5 Other (Specify) New Cathderal Cem. 22. Name and Address of Facility Sterling Ashton Scwab Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Ave., Catonsville, MD 21228 21. Signature of Fun Price Licensee MO/23 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner WEEN PNEUMONIA BILATERAL Sequentially list conditions, if any, leading to immediate cause. Enter Unitedlying Cause (Disease or iinjury Due to (or as a consequence of) SEPSIS WEEK Exami attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): WEEL Physician/Medical ON CHRONIC RENAL CUTE Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Pregnant at time of death signed by the at d be detached for 4 ☐ Pregnant a
9 ☐ Unknown 1 ☐ Yes 2 ☐ Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≥ HYPERTENSISN 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? DYSPHAGIA 24a, Was an ate has page 2 s autopsy performed' CEREBROVASCULAR ACCIDENT 1 Yes 2 No this certificate Yes 2 No Hospital or Attending Physician: 1 24 hours after death. Funeral Director: After this certifice within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Division of Vital Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ၉ 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) ATTENDING 00056948 15 2012 MARCH 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTIMORE MO 3455 WILKENS AVE #204 Monoma

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 2342 Physician/ 13 2013 Jalisa Daniel March Hurmon Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Upper Chesapeake Med.Center Harford Belair Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Hours Min 217-37-6816 Director 1 🗆 M 2 🔀 F 19 11-18-1992 Maryland 10c. City, Town or Location 10d. Inside City Limits notified at Director 28a-f Harford Edgewood Maryland 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö be 23a Funeral 1747 Dearwood Court 21040 USA or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, "natural", or ite Black, White, etc Completed by 1 ☐ Yes 2 🙀 No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2x No Specify. Specify: 3 ☐ Widowed 4 ☐ Divorced Black Year or Dates 27 is marked other than "nature traumatic event, the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Unemployed 12th Grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Jeffery Harmon Carla Reid 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a Carla Reid/Mother 1747 Dearwood Ct. Edgewood, Maryland 21040 Important; If item 2 any injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State $03 - 2^{\frac{1}{3}} - 12$ 1 Burial 2 Cremation 3 Removal from State Belair, Maryland 3/13/12 4 Donation 5 Other (Specify) Entombment Holly Hills Memi. Gardens 22. Name and Address of Facility Chatman-Harris Funeral Home 4210 Belair Road Baltimore, MD. 21206 21. Signati, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final amplications of Chronic Reval Jusufficience Physician/ disease or condition resulting in death) Medical **Examiner** encification tell villelitrisis if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Flomenluscherosis Soy mental that initiated events M80039296 resulting in death) Last Due to (or as a consequence of Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Hypertension, Pelvix Mass No No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of tarmon, Jalusa autopsy death? 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) မှ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA . Manner of Death 28a. Date of injury (Month, Day, Year) 28d. Describe how injury occurred Certificate: 8c. Injury at Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation Accident after death Director: / 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a

To the Funeral D

completely filled Medical 1 Destifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one

State Registrar DHMH 17 Rev 06-2011 SOO Upper Chosapachy Drive; Bel Air, MD 2101

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 12:49a M March 22 .2012 Physician/ Norman Forrest Henley Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Charlestown Care Center Catonsville If Under 1 Year If Under 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) Funeral (Month, Day, Yea OV . 7 . 191 Country) MA Days Hours 1 x M 2 □ F 96 543-22-0464 Director Nov. Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits 10b Count 10c, City. Town or Location 10a. State Director 1 Tyes 2 No MD Baltimore Catonsville 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral 21228 USA 707 Maiden Choice Lane, #8219 death v 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 No 45 - Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 2 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: 3 Widowed 4 X Divorced White "natural", Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) 1 and 2 should be filed within 72 f Health and Mental Hygiene. item 27 is marked other than " Elementary/Seconday (0-12) College (1-4 or 5+) Teacher Education 5+ 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Elijah Forrest Henley Laura Blanche Schnare 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 522 Dryden Road #E3G Ithaca, New York 14850 Christopher Lee Henley/son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition Date t. Page 1 aurthund of F Important: If it any injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory 3/23/2012 Baltimore, Maryland 22. Name and Address of Facility Signeture of Funeral Bervio Alicensee Stephanie Custer Cremation Society of MD. Inc. 299Frederick Road Baltimore MD 21228 23a. Part 1. Enter the chease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Congstore Pnysician disease or condition resulting in death) Medical Due to (or a a consequence of) Examiner dionyopeth Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or iinjury ASCVO anding physician and use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical that the death certificate be P.O. Box 68760 attending IF FEMALE: 23c. If ves, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? for Pregnant at time of death Yes 2 No 1 L Yes 2 L 9 Unknown s been signed by the should be detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Division of Vital Records, dises artery Were autopsy findings available prior to completion of cause of 24a. Was an Hospital or Attending Physician: The law to 24 hours after death.
 Funeral Director: After this certificate has b. ' ዕ autopsy death? ASW C 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) 25. Was case referred to medical completed filled in by the funeral director, Be examiner? Other: 2 × No 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) ျ 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28a. Date of injury 28c. Injury at Certificate: (Month, Day, Year) 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signatu

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 18, per fn, g925 3-30-12 sm. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Month LeRoy Hall Year 2340 M Will Oil Medical 4a. Facility Name (if not institution, give street and number) Examiner City, Town, or Location of Death County of Death 353 ockville Howard HUERVE Mont ganera 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours (Month, Day, Country)
New Jersey 1 1 M 2 □ F Year) 1918 Director 227-12-5623 93 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City Town or Location 10d. Inside City Limits Director MD Rockville Montgomery 1 X Yes 2 No. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 353 Howard Avenue 20850 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: 3 Midowed 4 ☐ Divorced Specify: Black Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Custodian City of Camden 10 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည William Hall Anna Lee Turnage -(unk) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Arcenia L. Owens / daughter 353 Howard Avenue Rockville, MD 20850 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Final Journey Crematory 3/26/12 Woodbine, MD 21. Signature of Feneral Service Licensee 22. Name and Address of Facility
Going Home Cremation Service P.O. Box 784 M01651 Clarksville Beverly L. Heckrotte, P.A. MD 21029 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician rene disease or condition Medical resulting in death) Due to (1) s a consequence of): Examiner neral Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Examine Hospital or Attending Physician; The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last and -trar Due to (or as a consequence of): burialattending physician for use as the burial Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day Year ed by the a detached f P.O. | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed l 23e. Did tobacco use contribute to the cause of death? þ Records, anemio 1 Yes 2 No 3 Probably 4 Unknown Completed been si 24b. Were autopsy findings available prior to completion of cause of 24a. Was an s certificate has b director, page 2 s autopsy performed? Yes 2 No death? 1 Yes 2 No Division of Vital director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 욘 1 Inpatient 2 ER/Outpatient 3 IDOA this 28a. Date of injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completed filled in by the funeral 1 X Natural 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 1 💢 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Grace Brockettuffman, M.D. 1355 Picca H.D. 1355 Piccond Drive Rockville, Maryland 20850 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Gregory Hillenburg 2012 10:35 A.[™] March Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Harford Upper Chesapeake Medical Center Bel Air Birthplace (State or Foreign Country) Funeral Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Hours 229-36-5691 Director 1**X** M 2 □ F Virginia May 8, 1933 78 Usual Residence of Deced permit. Page 1 and 2 should be filed within 72 hours after death with the Manyland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2X No Maryland Harford Perryman 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Completed by Funeral 1525 Maple Avenue 21130 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces 1 Never Married 2 X Married XYes Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify: If Yes, Give Specify: 3 Divorced 4 Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Engineer Telecommunications Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Kelly Nugent Hillenburg Anna Mae Vest 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21130 19a. Informant's Name/Relationship (Type, Print) Martha Ann Hillenburg / Wife 1525 Maple Avenue, P.O. Box 146, Perryman, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burlal 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) George's Cemetery 3/27/2012 Perryman, Maryland Mye of Funeral Service Licenses 22. Name and Address of Facility McComas Funeral Home. P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest k, or heart failure. List only one cause on each line. shock, or heart failu Immediate Cause (Final Stoge IV Onset and Death Physician/ Cell lina monall disease or condition Medical resulting in death) Examiner Securitally list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): attending physician and I for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 1 Live Birth
4 Pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Pregnant at time of death 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hospital or Attending Physician: The law requires Division of Vital Récords, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy perform 1 ☐ Yes 2 ☐ No Be Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Hospital မ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural injury 5 Pending 1 Yes 2 No ☐ Accident Investigation 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Gregory 28f. Location (Street and Number or Rural Route Number 4 Homicide determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 88 29c. License number 29d. Date signed (Month, Day, Year) 3/22/12 MO D0064615 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Upper Champake Drive Belair MO Dwelson 500 31. Date filed (Month, Day, Year) State 2 7 2012 Registrar DHMH 17 Rev 06-2011

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22/12

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Day 3 101 ,06 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Biltimory Le court Herrital 9. Birthplace (State or Foreign If Under 24 Hrs. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth (Month, Day,) Hours Min. 67 219-40-4178 Maryland 1945 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 1 X Yes 2 No N/A Baltimore City MD 10f. Zip Code 10g. Citizen of What Country? USA 21230 1802 Harman Ave 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 Yes 2XXNo White 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charlotte Sullivan Melvin Hall Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1802 Harman Avenue Baltimore Maryland 21230 Lee Harding-Husband 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) ☐ Burial 2 X Cremation 3 ☐ Removal from State Mar. ²⁴ 2012 Glen Burnie Maryland 4 Donation 5 Other (Specify) tlantic Crematory 22. Name and Address of Facility Ambrose Funeral Home of Lansdowne Funeral Service Licenses 2719 Hammonds Ferry Road Lansdowne Maryland 21227 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Toh Sequentially list conditions, Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy

Pry i jan/ Medical Examiner

Physician/

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Director

Completed by Funeral

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Be Completed by Physician/Medical

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Certificate:

Medical

29b. Signatu

only one)

30. Name and address of person who co

Examiner

Funeral

Director

show

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyghene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

ending physician and use as the burial-trans atter for u signed by the a should cate has n 24 hours after death.

e Funeral Director: After the bleted filled in by the funeral

the Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760

1 Yes 2 No 9 Unknown	4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown	World Sty 188									
Part II. Other significant conditions	contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown									
		24a. Was an autopsy performed? 1 \[\text{Yes} \ 2 \] No \[1 \] Yes \ 2 \[\] No									
25. Was case referred to medical	26. Place of Death (Check only one)										
examiner? 1 Yes 2 No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home	e 5 ☐ Residence 6 ☐ Other (Specify)									
27. Manner of Death 1 Natural 5 Pending 2 Accident Investigat	(Month, Day, Year) injury work? ion M 1 ☐ Yes 2 ☐ No	d. Describe how injury occurred									
3 Suicide 6 Could no 4 Homicide determine		8f. Location (Street and Number or Rural Route Number, City or Town, State)									
29a. Certifier 1 Certifying P	hysician: To the best of my knowledge, death occured at the time, date and place, and miner. On the basis of examination and/or investigation, in my opinion, death occurred at the	due to the cause(s) and manner as stated. e time, date and place, and due to the cause(s) and manner stated									

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

Registrar DHMH 17 Rev 7/2009

State

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To the i

se of death (Item 23a) (Type, Print)

000 32. Registrar's Signature

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2012 Christine March Harrison 10:20 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Stella Maris Hospice Timonium Baltimore Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Min Hours 213-38-5727 **Director** 75 1 M 2 X F 08-02-36 VA Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10b. County death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 □ No MD NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 839 N. Woodington Road 21229 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. African 1 Never Married 2 X Married ş 1 Yes 2 No 21215-0036 1 ☐ Yes 2 X No Specify: "natural" Completed Specify: American 3 Widowed 4 Divorced Year or Dates or other traumatic event, the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) 12th Grade Nurses Aide Genesis Nursing Home Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ George Frazier Mabel Ε. Colbert 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health item 27 Joseph Frazier-Brother 3915 Cedardale Road Baltimore, Maryland 21215 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Department of H Important: If ite any injury or otl Page 1 cemetery, crematory or other place)
Mt. Zion Cem. 1 $\!X\!\!\square$ Burial 2 $\!\square$ Cremation 3 $\!\square$ Removal from State 03-27-12 Lansdowne, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Wylie Funeral Home P.A. 638 N. Gilmor Street Baltimore, Maryland 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ COLON CANCER disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of) Cause (Disease or Injury that initiated events resulting in death) Last use as the burial-tran the attending physician and Due to (or as a consequence of): that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death HARRISON 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) 1 Live Birth 2 Fetal deat
4 Pregnant at time of death
9 Unknown in the past 12 months?
1 ☐ Yes 2 🛣 No
9 ☐ Unknown Month Day signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, CHRISTINE 1 Yes 2 No 3 Probably 4 Unknown peen Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autonsy Yes 2X No 1 Yes X No spital or Attending Physician: The hours after death.

neral Director: After this certificat by filled in by the funeral director, ps 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 🗶 No 4 ☐ Nursing Home 5 ☐ Residence 6X Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA HOSPICE 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred X Natural 5 Pending injury 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined To the Hospital
within 24 hours a
To the Funeral D Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. X Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TRACIE L. MORGAN, CRNP 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 Date filed (Month, Day, 32. Registrar's Sign MAR 27 2012 Registrar

Thinh 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Howe idico AM Medical 03 2012 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baitimore Riverside ANENUE ESSEX If Under 1 Year If Under 24 Hrs. **Funeral** Age (In vrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth Months Davs Hours (Month, Day, Year) Director 1 🗆 M 2 🔀 F 20-1914 PA ms 23a or 28a-f show must be notified at 10b. County and 2 should be filed within 72 hours after death with the Maryland 10c, City, Town or Location Director 10d. Inside City Limits BATIMORE Essex Yes 2 No 10f. Zip Code 10g. Citizen of What Country? Funeral USA Riverside 21221 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status than "natural", or iter he Medical Examiner 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. Completed by 1 Never Married 2 Married 1 Tyes 2 No If Yes Give 3 ₩ Widowed 4 □ Divorced White Year or Dates traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Paper Cup WORKER MFG Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) STELLA BRESSLER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) mb21040 Health tem 27 20a. Method of Disposition Department of Health Important: If item 27 any injury or other to DRIVE 5 Drewood 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Page 1 Date 1X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 1 Hill 03-27-2012 BALanore MD Signature of Funeral Service Licen 2134 Willewspring RD, 22. Name and Address of Facility 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition CHRONIC ISCHEMIC HEART DISEASE Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Completed by Physician/Medical To the Hospital or Attending Physician; The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ 23d. Date of delivery in the past 12 months?

1 Yes 2 X No
9 Unknown Pregnant at time of death Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably A Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy within 24 hours after death.

To the Funeral Director; After this certificate 2 No Yes 2 No 1 T Yes 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner?
1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 X Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending injury work? 2 \square No Investigation 6 Could not be Accident Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TRACIE L. MORGAN, CRNP 2300 DULANEY VALLEY RD. TIMONIUM,

X DHMH 17 Rev 06-2011

State Registrar

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12:00

2012

MARCH

2012

Registrar's Sign

MD 21093

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transi	Medical	(Check 2 Medical Exami	ician: To the best of my kno ner: On the basis of examinat	ion and/or inves	stigation, in my opini	on, death occurred a	at the time, date ar	nd place, and due to the	e cause(s) and manner stated.		
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DHMH 17 Rev 06-2011

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		4a. Facility Name (if no 6982 Milbrook			ımber)			o. City, To Pikesvi		ocation of	Death			c. County of I Baltimore		nty	
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Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-7 sho injury or other traumatic event, the Medical Examiner must be notified at once.	ဥ	19a. Informant's Name/ Kseniya Ve			Vife	7.1						ral Route Nur		•		Zip Code)	
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Physician /Medical	1 19	23 Part I. Enter the isease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.											Approximate Inter Between Onset a				
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Division of Vital Records, P.O. Box 68760, To the Haspital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	- 2≥	IF FEMALE; 23b. Was decedent preg past 12 months?	gnant in the	23c. If yes,	outcome of pred oirth	egnancy 2	Fetal	death	3	Ectopic p	regnanc	y	- 1	i. Date of de Month	elivery Da	y Year	
or use	sicia	past 12 months?	9 Unknown		nant at time of d		-	r (Specify									
by the a	Phy	Part II. Other significar		9 Onkir	own o death but not	resulting in '	the und	leriving ca	use give	en in Part I		23e. Did to	nbacco u	ise contribu	rte to th	ne cause of death?	
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Vita hysicis this ce	TO B		No He	lospital: 1 1	Inpatient 2	ER/Outpat	tient 3	3 DOA	Ot	her ₄ N	lursing l	Home 5	Residen	nce 6 🗸 (Other: 8	Scene	
J Of Jing Ph	E :	27. Manner of Death 1 ✓ Natural 5		28a. Date (Month	of Injury n, Day,Year)	28b. Time	of Inju			at Work?		3d. Describe I	how injur	ry оссиrred			
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To the Hospital within 24 hours a To the Funeral I completely filled	O	29a Certifier	rtifying Physicia			dge, death o	occurred	d at the tin	ne, date	and place	and du	ie to the caus	se(s) and	d manner as	stated	<u> </u>	_
To the How within 24 h To the Fur	edical		dicai Examiner:		of examination a												
FSFS	ž	29b Signature and title			March	J			icense n				29d. D	Date signed	(Month	n, Day, Year)	
		Ouls 5	hete_	Velo	100				D.C.M.	E.			Marc	ch 13, 20	12		
2		30. Name and address of Victor Weedn N			se of death (Iten		0.0/ [Raltimo	ro Stra	ot Balt	imoro	MD 2121	23				
St	ate				egistrar's Signat	tero A			- Sue	et, Dait	milore,	, 1010 2 122					\dashv
Regist		31. Date filed (Month, D.	9 7 2012	1 /2	man A	1 120	elle										ı

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		1	For State Registrar	State of Mary	-	tificate of E			Reg. No. 2	112	09428
	Physicia	n/	1. Decedent's Name (First, Middle, Last)					2. Date of Dea Month March 2		Year	3. Time of Death
	Medic	al	Jerold 4a. Facility Name (if not institution, give str		trich	4b. City Town or	Location of Death				11:50 p M
	Examin	Gilchrist Hospice				4b. City, Town, or Location of Death Towson			4c. County of Death Baltimore		
	Funeral		5. Social Security Number 6. Sex		yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt	h v, Year)	9. Birth Cou	nplace (State or Foreign ntry)
	Director		220-36-3322 Usual Residence of Decedent	M 2 □ F 71	Yrs.			July 2	23, 1940		MD
	and show I at	ro	10a. State 10b. County	10	c. City, Town or Loc	cation					10d. Inside City Limits
	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: I fitem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Director	MD Baltimo	re		Upperco					1 Yes 2X No
			10e. Street and Number	D 1		10f. Zip Code 21	5.5		10g. Citizen of U.S.		intry?
		Funeral	15814 Trenton 11. Marital Status	2. Was Decedent Ever	in U.S. 13. V	Vas Decedent of Hi f Yes, specify Cuba		ecify Yes or No-			ican Indian,
ထွ	ter de	by F	1 Never Married 2 🛭 Married	Armed Forces? 1 Yes 2 No If Yes, Give		f Yes, specify Cuba		Rican, etc.)		ack, White,	
9	ours af tural" al Exa	ted	3 Widowed 4 Divorced	Year or Dates.					Specif	VVII	ite
5	72 hc in "na Medic	Completed	15. Decedent's Edu (Specify only highest grade	completed)	(Give F	lent's Usual Occup kind of work done o O NOT use retired)	ation furing most of wor	king	16b. Kind of	Business/II	ndustry
212	within giene. er tha		Elementary/Secondary (0-12)	College (1-4 or 5+)		ng & A.C.			HV	AC	
nd	e filed ttal Hy ed oth event	To Be	17. Father's Name (First, Middle, Last)				18. Mother's Nar	ne (First, Middle, prence S		ne)	
Maryland 21215-0036	d Mer mark matic		Jacob Hert: 19a. Informant's Name/Relationship (Type		10h Mailin	ng Address (Street		_		State Zin	Codel
	d 2 shoalth an 27 is r trau		Donna I. Hertrich	, , , , , , , , , , , , , , , , , , , ,		4 Trento		Jpperco,		155	
Jre,	of Hear		20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 □ F		20b. Place of Dispo	sition (Name of natory or other place	e)	Date	20c. Location	a - City or T	Town, State
<u>E</u>	ment tant: I		4 Donation 5 Other (Specify)		Dulaney V	alley Men	n 3/28			_	lle, MD
Baltimore,	Depart Impor any in once.		21. Sign. Ve of Fun T ervice Licensee			Name and Addre		11824 Re			Road 21136
		J. Wayne Osterling ELINE FUNERAL HOME Reisterstown, 26a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,									Approximate
	hysician/		Shock, or hear failure. List only one cause on each line. Immediate Cause (Final disease or condition) Onset and Death Onset and Death								
	Medical Examiner		resulting in death)	Due to (or as a co	onsequence of):	4					
	LXammer	e	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury								-
X	lec ns t	Examiner									
Ø,	execur an and rial-tra	that initiated events resulting in death) Last C. Due to (or as a consequence of):									
2092	cate be executed physician and is the burial-transit	ledical									
687		/Me	IF FEMALE: 23b. Was decedent pregnant 23	3c. If yes, outcome of p			<u> </u>		23d. [Date of deli	ivery
XO	death certific he attending led for use as	Physician/M	in the past 12 months?	4 Pregnant at tin		Ectopic pregnancy Other (specify)				Month Day Year	
P.O. Box	es that the dea signed by the a i be detached i	hys	9 🗌 Unknown	g Unknown				1			11
<u>v.</u>	ss that igned be de	þ	Part II. Other significant conditions con	tributing to death but r	not resulting in the L	inderlying cause gi	ven in Part i.				the cause of death? robably 4 Unknown
rds	requires been sig should t	Be Completed						24a. Was			opsy findings available
ecc	e has l							auto perfe	psy ormed?	death?	completion of cause of
al B	sician: The law a certificate has k director, page 2 s		25. Was case referred to medical			26. P	lace of Death (Che		2 40	i Lies	2 🗆 110
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η of	ling P	ate:	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of injury (Month, Day, Ye	(ear) 28b. Time of injury	worl		28d. Describe	how injury occu	ırred	,
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Division of Vital Records,	s after s all Dire								_		
	Hospir 4 hour Funer tely fill	Medical	29a. Certifier 1 Certifying Physic (Check 2 Medical Examin	er: On the basis of exan	nination and/or inves	stigation, in my opini	on, death occurred	at the time, date	and place, and c	due to the c	cause(s) and manner stated.
	To the Hospital or Attending Physician: The law requires that the within 24 hours after death. To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detach.	Ψ̈́	only one) 3 Certifying Nurse	Practitioner: To the be	est of my knowledge	e, death occurred at 29c. Licens		piace, and due to	the cause(s) and 29d. Date sign		
	FSFÖ		> p/short	M	D	D7	1040		3/2	5/12	
	nox'		30. Name and address of person who co	mpleted cause of deat	h (Item 23a) (Type, I	Print)			1	1	
	8		ARATHI KUMAR 31. Date filed (Month, Day, Year)	6701 NC	Signature Si	T Suite	4105	Balti	uore 1	D	
	Sta Registr		MAR 2 7 20	32. 19 9 Har's	Signature	arkel					

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** Month 1:45PM Wilbur Hodges narch 22 2012 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Future Care Chesapeake Arnold Anne Arundel If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) Funeral Months Days Hours 1 X M 2 □ F 214-26-1023 81 Director MD 12/28/1930 Usual Residence of Decedent 10a, State 10b. Count 10c. City, Town or Location 10d. Inside City Limits show th and Mental Hygiene.
7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Modical Examina, must be notified at 1 ☐ Yes 🎖 ☐ No Director Anne Arundel MD Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8190 Poinsett Terrace 21122 Funeral death v 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 XYes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 💆 No Specify. 2 Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Self Employed Auto 6 permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any finjury or other traumatic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Hodges Kelly ပ Grace 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21679 Mr. Douglas Hodges / Son 13543 Rustling Oaks Drive Wye Mills, MD altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 🗡 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 03/28/2012 Glen Burnie, MD Atlantic Crematory 22. Name and Address of Facility 1 2nd Avenue SW 21. Signature of Funeral Service License MO1479 Glen Burnie, MD Singleton Funeral & Cremation Services, PA 23a. Part1. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest Immediate Cause (Final **Physician** Bladder disease or condition resulting in death) Caranomo /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. End of the cause Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) death certificate be executed attending physician and for use as the burial-transi resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 9 Unknown 5 Other (specify) signed by the a d be detached for ☐Yes 2☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 ☐ No 1 ☐Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Tes 2 TNo 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death

1 Alatural

2 Accident 28a. Date of Injury (Month, Day, Year) 28b. Time of Certification: 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) March 22, 2212

DHMH 17 Rev 1/2001

State Registrar 8601 Veterans Huy Millersville, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2012 Physician/ MARCH 23 SYLVIA HIRSCH 6:04 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 10212 CASCADE RUN COURT BALTIMORE OWINGS MILLS If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Director 220-05-1471 1 □ M 2 🛛 F Yrs 96 09/19/1915 Usual Residence of Decedent 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits notified at **Funeral Director** 1 🗌 Yes 2 🔀 No MD BALTIMORE OWINGS MILLS 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? the Medical Examiner must be 23a 10212 CASCADE RUN COURT 21117 filed within 72 hours after death all Hygiene. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. by 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2X No Specify: If Yes, Give Year or Dates Specify. Completed 3 X Widowed 4 Divorced WHITE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working giene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 10 HOMEMAKER OWN HOME Be other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Fis marked o 2 ABRAHAM MOSSOVITZ FANNIE GOLDMAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau FRANCINE LEVIN/DAUGHTER 4045 CARTHAGE ROAD, RANDALLSTOWN, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other p 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State ARLINGTON CHIZUK 4 ☐ Donation 5 ☐ Other (Specify) 03/25/2012 BALTIMORE, MD atyre of Funeral Service Lice see 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death MINKES Immediate Cause (Final Physician/ disease or condition resulting in death) Medical **Examiner** rdiony opathy Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence or that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical or Attending Physician: The law requires that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Pregnant at time of death 5 Other (specify) Day Year P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown Certificate: To Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe ☐ Yes 2 No 2 🗌 No 1 🗌 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred s after de... •al Director: Afte 1 Natural 5 Pending 1 🗌 Yes 2 🗌 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by Homicide 24 hours Medical **Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check

Registrar

To the within 2

State

only one

ENDING MO of death (Item 23a) (Type, Print) 3512

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Mar 23, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ HOWELL :40 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death HARFORD MOSPITA MEMORIAL GRACE HARFOR de HAVR Social Security Numbe 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Country) Georgia **Funeral** 1 □ M 2 🛚 F 5/22/1938 Director 212-36-5493 73 Usual Residence of Decedent or 28a-f show 10a. State 10b. County must be notified at Director 10c. City, Town or Location 10d. Inside City Limits MD Cecil: Perryville 1 ☐ Yes 2 🕅 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21903 USA 5290 Pulaski Hwy., Apt. 5 . Page 1 and 2 should be filed within 72 hours after death a ment of Health and Mental Hygiene.
tant: If item 27 is marked other than "natural", or items luny or other traumatic event, the Medical Examiner muliury or other traumatic event, the Medical Examiner mulius or other traumatic event, 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Completed by 1 Never Married 2X Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2X No Specify: 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 0 Homemaker At Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Albert Warlick Fanny Kitchens 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5290 Pulaski Hwy., Apt. 5, Perryville, MD 21903 Lowell D. Howell / Husband 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State West Chester, permit. Page 1 a
Department of F
Important: If ite
any injury or ot
once. Date 1 ☐ Burial 2 K Cremation 3 ☐ Removal from State R.A. Ferris & Co. 3/26/2012 4 Donation 5 Other (Specify) Pennsylvania Name and Address of Facility Tarring—Cargo Funeral Home, P.A. 333 S. Parke St, Aberdeen, MD 21001 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CEP Physician. 251 disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** 715 Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of) Cause (Disease or iinjury that initiated events burial-tran Due to (or as a consequence of): resulting in death) Last physician the burial Physician/Medical Records, P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) ____ in the past 12 months? Month Pregnant at time of death Day Year sertificate has been signed by the sector, page 2 should be detached g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 23e. Did tobacco use contribute to the cause of death? RILL 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? page performed? Yes 2 No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No Hospital Other: မ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? Certificate: 28b. Time of 28d. Describe how injury occurred 1 Accident
2 Accident
3 Suicide
4 Homicide 5 Pending within 24 hours after death.

To the Funeral Director: Af completed filled in by the fu 1 Yes 2 No Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier only one) 29b. Signature and title of certifier arri 82a 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HAR FORD SOUTH UNION

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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	1- For State Certificate of Death Reg. No.				eg. No.					
Physicia edical Exami		1. Decedent's Name (First, Middle,Last) Jody Marie Johnson				2. Date of Deat Month March 8, 2	th Day Year 2 012	3. Time of Death 1456 hrs		
		4a. Facility Name (if not institution, give street and number) Anne Arundel Medical Center		4b. City, Town, o	r Location of Deal	h	4c. County of D			
Funeral Director		5. Social Security Number 215-66-7912 6. Sex 7. Age (In yrs, last birtho	day) If Under 1 Ye Months Da Yrs.			th(MM/DD/YYYY) 9. 23 1955	Birthplace (State or reign Washington Country) D.C.		
Maryland 28a-f show any d at once.	ەر د	Usual Residence of Decedent 10a. State 10b. County Maryland Anne Arundel	Oc. City, Town of					10d. Inside City Limits 1 Yes 2 No		
eath with the Maryland items 23a or 28a-f sho ust be notified at once.	Director	10e. Street and Number 15 Summer Hill Park		10f. Zip Code 21023		10	0g. Citizen of What 0	Country?		
2 5 8	To Be Completed by Funeral	11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Married 3 Widowed 4 Divorced of Pates:	ver in U.S.	13. Was Decedent of H If Yes, specify Cuba 1 Yes 2 X N	n, Mexican, Puert		White, et	nerican Indian, Black, c. hite		
036 tihin 72 hours afte ne. r than "natural", fedical Examiner		15. Decedent's Education (Specify only highest grade complete Elementary/Secondary (0-12) College (1-4 or 5+)) du	ecedent's Usual Occupa uring most of working lif ersonal Car	e. DO NOT use re	work done tired)	16b. Kind of Busine Health	ss/Industry		
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica		17. Father's Name (First, Middle, Last) Morris John Tretick	•		Mary C	arr	Maiden Surname)			
MD 21 d 2 should lth and Me n 27 is ma		19a. Informant's Name/Relationship (Type, Print) John Tretick	381		eet Ches	apeake E	Beach, Mar	yland 20732		
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hou Department of Health and Menhal Hygiene. Important. If item 27 is marked other than "nati		20a. Method of Disposition 1 Burial 2 XCremation 3 Removal from State 4 Donation 5 Other Specify:	cremator	Disposition (Name of co y or other place) Cremation	03/		Hanover,	Maryland		
		21. Signature of Funeral Service Licensee Muchael Masquille		6009 Harf	ord Road	Baltimo	ore, maryl			
Physician /Medical ±xaminer		23a. Part I. Enter the disease for complications that caused the failure. List only one cause on each line. Immediate Cause (Final disease a. Hypertension	ve Card			or respiratory arre	est, shock, or heart	Approximate Interval Between Onset and Death		
	Completed by Physician/Medical Examiner	or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Due to (or as a consequence of):								
		cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence)								
760, cate be executed physician and the burial - transit		d. X UNPENDED ☐ AMENDED 23a,27,per me,g925 3-29-12 sm								
		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ✔ Unknown 23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at tirr 9 ☐ Unknown	2 [Fetal death 3 Other (Specify)	Ectopic pregn	ancy	23d. Date of deli	very Day Year		
		Part II. Other significant conditions contributing to death b	ut not resulting i	in the underlying cause	given in Part I.			to the cause of death?		
Division of Vital Records, P.O. Box 68' at or Attending Physician: The law requires that the death certificate death. al Director: After this certificate has been signed by the attending led in by the funeral director, page 2 should be detached for use as						24a. Was a autops perfor	sy prior med? death			
ital ician: s certif rector,	Be	25. Was case referred to medical examiner?	2 🗸 ER/Outs		Other Nursi		Residence 6 0			
on of V ending Phys ath. or: After thi	tion: To	27. Manner of Death 1 X Natural 5 Pending 28a. Date of Injury (Month, Day, Year	28b. Tir	me of Injury 28c. Inju	ury at Work? Yes 2 No		now injury occurred	ner.		
Division of V To the Hospital or Attending Phy- within 24 hours after death. To the Funeral Director: After tl completely filled in by the funeral	Certification	2 Accident Investigation 3 Suicide 6 Could not be determined letermined (Specify) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route or Town, State)								
o the Hosp ithin 24 hor o the Fune empletely fi	Medical C	29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examinant manner stated								
) L 3 F 8	Me	29b. Signature and title of certifier Pamel Author (1997)		29c. Licen O.C.	se number		29d. Date signed (
\Diamond		30. Name and address of person who completed cause of death (Item 23a) Pameta E. Southall, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223								
St Regist		31. Date filed (Month, Day, Year) 32. Registrar's	Signature	/						

12-02297 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Dexter Maurice Jones, Jr. State of Maryland / Department of Health and Mental Hygiene 2012 09433 1- For State Certificate of Death Rea. No. Registra 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ 3. Time of Death 2215 hrs **Medical Examiner** Dexter Maurice Jones Jr. March 20, 2012 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death University Hospital Baltimore 5. Social Security Number 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. **Funeral** Foreign Mary Land Months Hours Aug. 21, 1988 Days Director 215-21-9909 23 1X M 2 F Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County Howard Ellicott City Maryland 1 Yes 2 X No nr items 23a nr 28a-f show must be notified at once. permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked nither than "natural", nr items 23a nr 28a-f sho injury or other traumatic event, the Mudical Kraminer must be notified at once Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21043 3169 West Springs Drive #D USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Funera 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black 1 X Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc. Yes 2 X No Specify: Black If Yes, Give Year 1 Yes 2 No specify: 3 Widowed 4 Divorced 2 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Armark Elementary/Secondary (0-12) College (1-4 or 5+) Culinary Chef 21215-0036 1 Year 12th grade 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Montra Michelle Womack Dexter M.Jones Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code), 21 0 4 3 19a. Informant's Name/Relationship (Type, Print) 8 3169 West Springs Dr. #D Ellicott City, MD. Montra Cooper/Mother Date 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Saltimore, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 3-29-12 Baltimore, Maryland Greenmount Cemetery Donation 5 Other Specify: 22. Name and Address of Facility Chatman-Harris Funeral Home ture of Funeral Service Li see 5240 Reisterstown Rd.Baltimore, Md. 21215 23a, Part I, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** failure. List only one cause on each line. /Medical Death a. Gunshot Wound of Right Forearm with Re-Entry into Right Flank Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Examiner if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed and Physician/Medical x AMENDED 28b, per me, g927 5-11-12 sm UNPENDED attending physician or use as the burial Box 68760, IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 1 Live birth Fetal death 3 Ectopic pregnancy Year 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? P.O. contributing to death but not resulting in the underlying cause given in Part I. <u>ā</u> 1 Yes 2 ✓ No 3 Probably 4 Unknown Completed Records, 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed death? page ✓ Yes 2 No 1 🗸 Yes 2 No 26.Place of Death (Check only one) 25. Was case referred to medical Division of Vital Other Nursing Home 5 Residence 6 Other After this funeral dire 1 Yes 2 No 28a. Date of Injury (Month, Day Year) Mar 20, 2012 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: To the Bospital or Attenues, within 24 hours after death.

To the Funeral Director: Af Subject shot 0000 hrs Natural 5 Pending 1 Yes 2 ✔ No fd 9:28 pm 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 6 Could not be Suicide or Town, State) 1800 Ashburton Street, Baltimore, MD determined (Specify) Local Street 4 V Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b Signature and title of certifier 29c, License number 29d. Date signed (Month, Day, Year) O.C.M.E. March 21, 2012 PR 30. Name and address of person who completed cause of death (Item 23a) 900 W. Baltimore Street, Baltimore, MD 21223 Victor Weedn MD JD Assistant Medical Examiner 31. Date filed (Month, Day, Year) State MAR Registra

DHMH 17 Rev 1/2001

DOME

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 1tem 5 per th g926 4-16-12 vt.

State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth Month Physician/ Landis Johnson Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Good Samaritan Hospital Baltimore Social Security Number 8. Date of Birth (Month, Day, Year) Nov • 7 • 1945 6 Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Days Hours 1 🔀 M 2 🗌 F New Jersey -9735 Director 138 66 Usual Residence of Decedent or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 23a or 28a-f sho Important: If item 25 is marked ther than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Baltimore 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21212 5401 Ready Avenue USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12, Was Decedent Ever in U.S Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 X Married þ If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: Black Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Bakery 9th grade <u>Sanitation Worker</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Landis Johnson |Molly Halton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbie Johnson/Wife 5401 Ready Ave.Baltimore, Md. 21212 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) MT.Zion Cemetery 03-30-12 Landsdowne, Maryland 21. Signature of Funeral Service Licen 22. Name and Address of Facility Chatman-Harris Funeral Home 4210 Belair Rd.Baltimore, Maryland 21206 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Carcha disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Exami nding physician and use as the burial-transit • Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
• Z4 hours after death.
• Funeral Director: After this certificate has been signed by the attending physician and eted filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No Month Day Year P.0. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 2 No 1 🗌 Yes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Man of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

Cartilying Merica Practioner: It is consistent to the cause (s) and manner stated

Cartilying Merica Practioner: It is consistent to the cause (s) and manner stated (Check 29b. Signature and title of certifier 29c. License number address of pe/soi completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) Registrar

DHMH 17 Rev 7/2009

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 02:35AM William Norris Jackson March 2012 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Sinai Hospital Baltimore None Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) **Funeral** 216-20-2814 Director 86 1 XXM 2 □ F 09/07/1925 Maryland Usual Residence of Decedent 28a-f show ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits Director 1XX Yes 2 □ No Maryland None Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6012 Hunt Ridge Road 21210 USA 12. Was Decedent Ever in U.S. Armed Forces? XX Yes 2 ☐ No WIII If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2xxx No Specify: Completed 3 Widowed 4 Divorced Specify White Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) and Mental Hygier is marked other t IRS Agent Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ William Norris Jackson Sr Essie Horner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau Wife Geraldine Fisher Jackson 6012 Hunt Ridge Road #2721 Baltimore, Maryland 21210 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Burial 2 X Cremation 3 - Removal from State GreenMount Crematory 03/28/2012 |Baltimore, Maryland ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home Inc gnature of Funeral S 6500 York Road Baltimore, Maryland 21212 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final subdural hematoma due Physician subacute disease or condition resulting in death) on Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months? Year Month Day Pregnant at time of death 1 Yes 2 9 Unknown 2 No q Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Emphysema 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 2 | No မ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work?
1 ☐ Yes 2 ☑ No 28d. Describe how injury occurred 1 - Natural 5 Pending injury M 2 Accident 3 Suicide Investigation 1800 Fall 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Home 28f. Location (Street and Number or Rural Route Number) 4 Homicide determined City or Town, State) 6012 HUNTRIAGE Oad, Calfinare; MS 21210 24 hours Funeral Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 3/25/12 Haritha D65718 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) OF BALTIMORE SINAT PEND6I HOSPITAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State Registrar

Jackson

Lnown

32. Registra 's Sign

State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Ellen Rose Johnston narch Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Meritus Medical Center Hagerstown Washington Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Age (In yrs. last birthday) Days Min. Hours 214-32-4694 77 Director 1 🗆 M 2 🕱 F 11/1/1934 Marvland or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Williamsport Washington ö 10e. Street and Numbe 10g. Citizen of What Country? ems 23a or must be r Funeral 8 Oaktree Lane, Apt. 21795 U.S.A. items 2 · death v Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Examiner Black, White, etc. ö þ 1 Never Married 2 Married Yes 2 No Maryland 21215-0036 If Yes, Give Year or Dates. 1 Yes 2 No Specify "natural", Completed 3 Divorced White event, the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry ມe filed wn.. ⁺tal Hygiene. `er than "r (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Titling Clerk Motor Vehicle Be permit. Page 1 and 2 should be file
Department of Health and Mental H
Important: If item 27 is marked oil
any injury or other trees. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 John Dennis Hewett Alma Merle Moon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Guy R. Johnston / Spouse 8 Oaktree Lane, Apt. G. Williamsport, MD 21795 altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 🕏 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cedar Lawn Mem. Park : 3/23/2012 Hagerstown, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rest Haven Funeral CHapel 5.Mall 1601 Pennsylvania Ave., Hagerstown, MD 21742 23a. Part 1. Enter the disease, or compil alons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician homa 4mp disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** 1 m Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury Due to for as a consecuence of: Exami Pneumon Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) burialattending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Month Dav Pregnant at time of death Year 1 Yes 2 9 Unknown 2 No the 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 10 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an tate has bage 2 s autopsy performed certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: nours after death.

Neral Director: After this confilled in by the funeral dire 2 မ 1 \(\text{Yes} \) 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, funeral (27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28a. Date of injury 28b. Time of Certificate: 28d. Describe how injury occurred (Month, Day, Year) 1. Natural iniury 5 Pending Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined City or Town, State) within 24 hours a

To the Funeral E

completely filled Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 1060396 19/12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ch opal MUR SHED State Registrar

			State of Maryland / Dep	artment of Health and N	/lental Hygie	ne								
		_1		rtificate of Death	Reg.	No. 2012	09437							
	Dhysisia		1. Decedent's Name (First, Middle, Last)		Date of Death Month	Dav Year	3. Time of Death							
	Physicia Medic	al .	Roy Arthur Johnson		March :	$2\overset{\text{Day}}{3}$, $2\overset{\text{Year}}{0}$ 1								
	Examin	er	4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Deat Carrol								
-			Carroll Hospice 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday,	Westminster If Under 1 Year If Under 24 Hrs.	8. Date of Birth		thplace (State or Foreign							
13.	Funeral Director		330-07-9642 1⊠M2□F Vrs	Months Days Hours Min.	(Month, Day, Yea	ar) Co	untry)							
			Usual Residence of Decedent		06/20/19	028 11.	linois							
	/land f sho ed at	itor	10a. State 10b. County 10c. City, Town or L				10d. Inside City Limits							
	Mary 28a- otifie	Director	MD Carroll New Win				1 🔀 Yes 2 🗆 No							
	th the		10e. Street and Number	10f. Zip Code	, i	. Citizen of What Co	ountry?							
	ms 2 mus	Funeral	303 Lambert Avenue	21176 Was Decedent of Hispanic Orlgin? (Sp.		U.S.A.	rican Indian							
10	or ite	by Fu	11. Marital Status 1 □ Never Married 2 ☒ Married 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☒ No	If Yes, specify Cuban, Mexican, Puerto		Black, White								
036	s afte ral", Exan	g pa	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates.	1 🗌 Yes 2 🔀 No Specify:		Specify: W	nite							
2-0	72 hours after death with the Maryland n "natural", or items 23a or 28a-f sho Aedical Examiner must be notified at	Completed	15. Decedent's Education 16a. Dec (Specify only highest grade completed) (Giv	edent's Usual Occupation e kind of work done during most of work	ina 16	b. Kind of Business/	Industry							
21	within 72 /giene. ser than '	E I	Elementary/Secondary (0-12) College (1-4 or 5+)	DO NOT use retired)		Ministry								
2	s filed within 72 hours after death with the Maryland tal Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	امها	17. Father's Name (First, Middle, Last)	Pastor 18 Methods Nor	ne (First, Middle, Maid									
anc	oe filed intal Hy ced oth	10 E	Roy A. Johnson, Sr.	Elizabe		eber								
2	should be file and Mental H is marked o			ling Address (Street and Number or Rur			o Code)							
M	12 sh alth ar 27 is r trau			Lambert Avenue, N										
re,	of Health and Mente of Health and Mente fitem 27 is marked r other traumatic e		20a. Method of Disposition 20b. Place of Disposition		7	c. Location - City or								
<u>m</u>	Page nent ant: It			Gifts Registry 03/2	6/2012 На	enover, M	*							
Baltimore, Maryland 21215-0036	permit. Page 1 a Department of F Important: If ite any injury or of	l			natomy Gi		*							
ш	205 20			522 Connelley Dr.		Hanover,								
		Ш	23a. Part 1. Enter the disease or complications that caused the death. Do not enshock, or heart failure. List only one cause on each line.				Approximate Interval Between Onset and Death							
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687	rtifica ing pl e as t	/Me	IF FEMALE: 23c. If yes, outcome of pregnancy											
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a	ician: The certificate rector, pag	Be	25. Was case referred to medical examiner?	26. Place of Death (Chec			11.7/2/21/21							
\equiv	Physicia this cert ral direct	은	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpat		ome 5 Residenc		(NYATTEN							
סר	ding Ph h. After thi funeral	ate	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 28a. Date of injury (Month, Day, Year) injury (Month, Day, Year)		28d. Describe how i	injury occurred	pusition							
sion	death ctor: A y the f	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm,		28f. Location (Stree	et and Number or Ru	ıral Route Number,							
Division	after Directory		4 Li Homicide determined building, etc. (Specify)		City or Town, S									
_	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transi	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, deat 2 Medical Examiner: On the basis of examination and/or inv	n occurred at the time, date and place, a	and due to the cause	(s) and manner as s	tated.							
	To the Hi within 24 To the Fu	Me	only one 3 Certifying Nurse Practitioner. To the best of my knowled	ge, death occurred at the time, date and p	lace, and due to the c	ause(s) and manner	as stated.							
	with void		29b. Signature and title of certifier	29c. License number	29d	Date signed (Mont	h, Day, Year)							
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			30. Name and address of person who dompleted cause of death (Item 23a) (Type	2/20/21/54	Usilni.	ndev.	MODIS							
	Sta	te	31. Date filed (Month, Day, Year) 32. Registrar's Signature	a A	Very IU									
	Registr		MAD 9 7 2012 /2 mm 8. Alan											

DHMH 17 Rev 06-2011

12-02298

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Jesse Jacobs State of Maryland / Department of Health and Mental Hygiene 1. For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day March 21, 2012 Medical Examiner 0030 hrs Jesse Jacobs 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Baltimore County** 11 Nightingale Way 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or **Funeral** Director Months Davs Hours Min. 212-08-2204 1 X M 2 F 41 06/05/1970 Countryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No MD Baltimore Lutherville Pages I and 2 should be filed within 72 hours after death with the Maryland rent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11 Nightingale Way, B7 21093 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Mantal Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, 1 Never Married 2 Married Armed Forces' White etc 2 X No 1 Yes 4 Divorced If Yes, Give Year 3 Widowed 1 Yes 2 No specify: White Specify: 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) MD 21215-0036 Cook Restaurant 17. Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Surname) Jesse Jacobs III Patricia Matthews 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia A. Jacobs / Mother 11 Nightingale Way, B7, Lutherville, MD 21093 traums 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State crematory or other place) Burial 2 Cremation 3 Removal from State ment Chesapeake Crematory 3/23/2012 Beltsville, MD Donation 5 Other Specify 21. Signature of Funeral Service License Dorota Marshalli Maryland Cremation Services, PO Box 1413 Baltimore, MD 21203 23a. Part I. Enter the discrete, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Approximate Interval failure. List only one cause on each line een Onset and /Medical Death a Intracerebral Hemorrhage Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Hypertensive Atherosclerotic b. Cardiovascular Disease in association with cocaine use Sequentially list conditions, Examiner Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last Physician/Medical X UNPENDED AMENDED 23a,-b,27, per me, g_{926} 4-2-12 sm attending physician or use as the burial The law requires that the death certificate be Division of Vital Records, P.O. Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 1 Live birth 3 Ectopic pregnancy Fetal death Day Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown the signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>م</u> 1 Yes 2 No 3 Probably 4 V Unknown Completed s been s 24b. Were autopsy findings available autopsy prior to completion of cause of icate has b nerformed' death? this certificate Yes 2 No 2 No 1 🗸 Yes 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 🗹 Other: Scene 1 Yes 2 No 28c. Injury at Work? After 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred 1 X Natural Pending 1 Yes 2 No hours after death. Director: Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City Could not be Suicide or Town, State) within 24 hours a To the Funeral 1 determined Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) lue O.C.M.E. March 21, 2012 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 Ana Rubio MD. 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Donald Quinton Kelly 211 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death ltimore Maryland General If Under 8. Date of Birth 1 Year If Under 24 Hrs. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 🕱 M 2 🗆 F Months Hours Min (Month, Day, Year) 217-66-5015 56 Yrs **Director** Maryland June, 14, 195 Usual Residence of Decedent 28a-f show 10a. State 10b. County 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location the Maryland 10d. Inside City Limits Director Maryland Baltimore 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21215 3400 Virginia Avenue USA permit. Page 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: Black 3 Widowed 4 🙀 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Private Cook 11th grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Reginald Kelly Mable Allen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) portant: If item 27 it y injury or other trat Princess Clifton/Sister N.Monastery Ave.Baltimore, Md.21229 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Greenmount Cemetery 3-29-12 1 Burial 2 K Cremation 3 Removal from State Baltimore, Maryland 4 Donation 5 Other (Specify) 21. Signatur of Funeral Service Licen 22. Name and Address of Facility Chatman-Harris Funeral Home 5240 Reisterstown Rd. Baltimore, Md. 21215 any ir Harre len 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause one of line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner y physician and is the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 attending p 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) the 9 Unknown Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably W Unknown been sir 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes No page 2 certificate 1 Yes 2 No Be 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) e ZNo Hospital မှ 1 🗌 Yes ER/Outpatient 3 DOA Inpatient 2 this 27. Manner of Death Date of injury 28b. Time of 28c. Injury at work?
1 Yes 2 No Certificate: 28d. Describe how injury occurred After (Month, Day, Year) injury 10 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 24 hours after dea: Funeral Director: 6 Could not be within 24 hours after der
To the Funeral Directo
completed filled in by th 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 🔀 Çertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioners to the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 [only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MAR 27

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State

Registrar

Donald He

32. Registrar's Si

2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day Month Edith Mae Kuhn Medical March 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 117 Woodland Avenue Baltimore Dundalk Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** Age (In vrs. last birthday) 8. Date of Birth Days (Month, Day, Year) Nov. 27, 1928 1.L. M 2 X F **Director** Yrs. 220-24-7283 83 Usual Residence of Decedent or 28a-f show 10a. State 10b. County item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at filed within 72 hours after death with the Maryland 10c. City, Town or Location Director MD **Baltimore** Dunda1k 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21222 United States 21 Patapsco Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Force Black, White, etc. 1 ☐ Yes 2 🗓 No If Yes, Give by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify Completed 3 XWidowed 4 Divorced Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other that any injury or other traumatic event, the N ones. Banker Banking 12 Years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Elizabeth Gill William Humphrey 19a. Informant's Name/Relationship (Type, Print) 19b, Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
117 Woodland Ave. Dundalk Marysland 212 Catherine Ann Pugh (Daughter) Dundalk, Maryland 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State awn Cemetery 4 Donation/ 5 Other (Specify) 9ak∕ 3/27/2012 Baltimore, Maryland 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Signature of Funeral Service License Dundalk, Maryland Wise Ave. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final 5 tay Physician/ Medical Examiner resulting in death) Due to (or as a conseq nce of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to (or as a consequence of). Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): attending physician for use as the burial Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 month 4 ☐ Pregnant at time of death 9 ☐ Unknown **To the Funeral Director:** After this certificate has been signed by the *s* completed filled in by the funeral director, page 2 should be detached it 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by Division of Vital Records, Completed 24a. Was an autopsy 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 1 ☐ Yes 2 ☐ No မှ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural injury work?
1 Yes 2 No 5 Pending 2 Accident
3 Suicide М Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide determined

Interval Between Onset and Death 23d Date of delivery Year 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No Daughter's 4 Nursing Home 5 Residence 6 Nother (Specify) residence 28f. Location (Street and Number or Rural Route Number, City or Town, State Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 26117 Crile

3. Time of Death

10:00

10d. Inside City Limits

1 Tes 24 No

Birthplace (State or Foreign Country)

White

Maryland

Year

2012

State Registrar

31. Date filed (Month, Day,

29a. Certifie (Check

30. Name ap

only one) Signature

32. Registrar's Signature

address of person who completed cause of death (Item 23a) (Type, Print)

within 24 hours a

0

29c. License number

000

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registral Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ March 223y **20**12 10:55 Рм rrest Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Prince George's 3800 Enfield Chase Ct., Unit 327 Bowie 9. Birthplace (State or Foreign 8. Date of Birth If Under 1 Year If Under 24 Hrs Social Security Number 7. Age (In yrs. last birthday) Funeral Min Country 1**X** M 2 □ F Days 0971671937 74 Tennessee **Director** 214-32-8761 Usual Residence of Decedent or 28a-f show notified at 10d. Inside City Limits 10c. City, Town or Location 10a. State filed within 72 hours after death with the Maryland Director 1 X Yes 2 No MD Prince George's Bowie 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ö ral", or items 23a o Examiner must be Funeral USA 20716 3800 Enfield Court Apt. 327 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Black White etc. Armed Forces? 2 1 Never Married 2 X Married 1 ☐ Yes 2 ☐XNo If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Specify: Black "natural", Completed 3 Divorced 4 Divorced Year or Dates the Medical 16a Decedent's Usual Occupation 16b Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'am yinuy or other traumatic event, the Meone. College (1-4 or 5+) Elementary/Seconday (0-12) Federal Government Manager Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ၉ Carrie Simpson Ernest E. Kyle, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3800 Enfield Court, Apt. 327, Bowie, MD 20716 Dorothy Kyle/Spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Fort Lincoln Cemetery 03/30/2012 Brentwood, Maryland Qonation 5 Other (Specify) Signature of June II Service Licenses 22. Name and Address of Facility Beall Funeral Home 6512 NW Crain Hwy, Bowie, Maryland 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Vears Immediate Cause (Final Metastatic Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner constitution liet conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months?
1 ☐ Yes 2 ☐ No Year Pregnant at time of death 5 Other (specify) 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably Completed 24b. Were autopsy findings available 24a Was an autopsy performed? Yes 2 No prior to completion of cause of 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? **Division of Vital** 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5X Residence 6 Other (Specify) 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 🗌 Yes ൧ 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie (Check Certifying Morse Prectioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of ACO00937

State Registrar

0

9200 Basil Ct Ste 200

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

cernold

filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State 09442 Certificate of Death Reg. No. 3. Time of Death Decedent's Name (First, Middle, Last) 2. Date of Death MURCH Physician/ 201 12170 KIRSITEN Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Examiner** HOWARD COLUMBIA 10850 GREEN MOUNTAIN CIRCLE, #216 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number **Funeral** (Month, Day, Year) Hours Min 102-14-0888 89 Director 1 🗆 M 2 🗗 04/03/1922 NY Usual Residence of Deceder or 28a-f show be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 Yes 2 X No MD HOWARD COLUMBIA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? be "natural", or items 23a o Funeral 10850 GREEN MOUNTAIN CIRCLE, #216 21044 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give 14. Race - American Indian 1. Marital Status Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: WHITE 3 X Widowed 4 Divorced Completed Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Il Hygiene. I other than "r Elementary/Secondary (0-12) College (1-4 or 5+) BOOKKEEPER MEDICAL and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ KANTIN SARAH COHEN FRANK permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11850 FARSIDE ROAD, ELLICOTT CITY, MD 21042 SUSAN DRAPKIN / DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) BETH EL MEMORIAL PARK: 03/26/2012 RANDALLSTOWN, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition cerz Physician/ onge nonth Medical resulting in death) Due to (or is a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a nonsequence of that the death certificate be executed attending physician and I for use as the burial-trar Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?

1 Yes 2 No Day Pregnant at time of death 9 Unknown P.O. I þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò be 1 Yes 2 No 3 Probably 4 Unknown Records, Hospital or Attending Physician; The law requires Completed . Were autopsy findings available prior to completion of cause of 24a. Was an autopsy has page 2 death? 1 Yes 2 No After this certificate 1 Yes Division of Vital filled in by the funeral director, 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Hospital Other: 2 No 4 ☐ Nursing Home 5 ☐ Residence ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28d. Describe how injury occurred 28c. Injury at Natural 5 Pending 1 Ves 2 No Accident Investigation after death 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number determined City or Town, State) 24 hours Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 24 hou

To the Funer

completely fi 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License numbe and address of person who completed cause of death (Item 23a) (Type, Print) ERS

DHMH 17 Rev 06-2011

State Registrar

119443 State of Maryland / Department of Health and Mental Hygiene 2 1 2 For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Link Betty Roth March 23,2012 12:05 A M Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner Catonsville Baltimore Brightview Asst. Living Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Numbe 7. Age (In yrs. last birthday) **Funeral** Hours 215-16-1295 1 □ M 2 🏋 F Director 88 Dec. 28, 1923 Maryland Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10c. City, Town or Location at Director notified a MD Baltimore Rosedale 1 Yes 2 No 10e, Street and Numbe 10f. Zip Code 10g, Citizen of What Country? ö must be 21237 Funeral Road 23a 1745 Ellinwood USA 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status "natural", or iten edical Examiner Armed Force 1 Never Married 2 Married þ 2X No ☐ Yes Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 XNo Specify: Specify: If Yes, Give Completed 3 😾 Widowed 4 🗌 Divorced Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Own Home Homemaker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) and Mental Fishers is marked o ပ Valetta Galloway Stanley Lee Roth Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1745 Ellinwood Road, Rosedale Maryland 21237 item 27 John Link-Son 20c. Location - City or Town, State 20a, Method of Disposition 20b. Place of Disposition (Name of Important: If it any injury or o once, 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Loudon Park Cemetery Mar.27.2012 Baltimore Maryland 22 Name and Address of Facility Ambrose Funeral Home Inc. Signature of Funeral Service Licensee 1328 Sulphur Spring Road Arbutus Maryland 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onget and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of) Cause (Disease or injury burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 the yes, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy

Consent at time of death 5 Other (specify) IF FEMALE: 23d. Date of delivery 23b. Was decedent pregna in the past 12 months? Month Year Yes 2 No P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Division of Vital Records, Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an mass 2 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) assisted Be examiner? Other: livina 2-11/0 ျ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Spec 27. Manner Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Watural work? 1 ☐ Yes 2 ☐ No s after deau... ral Director; Aff 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral I 🖟 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one (Item 23g) (Type, Print)

(Item 23g) (Type, Print)

(Item 23g) (Type, Print)

(Item 23g) (Type, Print)

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(Item 23g) (Type, Print)

(Item 23g) (Type, Print)

(Item 23g) (Type, Print) Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ March 24, 2012 MARY ELIZABETH 3:05P Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Charlestown Baltimore Baltimore Social Security Number If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday **Funeral** 1 □ M 2XX Months Hours Min 01/26/191 Year) 215-10-8975 Delaware 101 Director Usual Residence of Decedent 28a-f show 10a. State 10b. County 10d. Inside City Limits with the Maryland 10c. City. Town or Location the Medical Examiner must be notified at Director 1 ☐ Yes XX No Maryland Baltimore Baltimore 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? 23a by Funeral 21228 719 Maiden Choice Lane USA items permit. Page 1 and 2 should be filed within 72 hours after death \text{Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian 11. Marital Status Armed Forces? Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. If Yes, Give Year or Dates 3 Nidowed 4 Divorced Completed White Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည Alvi Haywood Barrett Annabelle Baxley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara A Peters DTR O Box 1416 Brooklandville, Maryland 21022 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 03/30/2012 Moreland Memorial Park ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home Inc 6500 York Road Baltimore, Maryland 21212 23a. Part 1. Enter the disease, or complic enter the mode of dying, such as cardiac or respiratory arrest, ons that caused the death. Do not Approximate Interval Between Onset and Death shock, or heart failure. List only Immediate Cause (Final disease or condition Phylician allo To Mel Medical resulting in death) Due to for as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence or, Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 yes, outcome of pregnancy

Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day 5 Other (specify) Month Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 \(\sum \) Yes \(2 \sum \) No 24a. Was an autopsy certificate Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: ည 1 🗌 Yes 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at work?
1 Yes 28d. Describe how injury occurred After injury 1. Natural 5 Pending 2 🔲 No Accident Investigation 24 hours after deat Funeral Director; Suicide Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the F 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 000 220 90

Registrar

DHMH 17 Rev 7/2009

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Lewis 11:35 A Frances march Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Butimore Butimore Hospice 8. Date of Birth 1 Year If Under 24 Hrs. g. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Min (Month, Day, Year) Director 1 🗆 M 2 🔀 F WEST VIRGINIA 12/10 23a or 28a-f show 10d. Inside City Limits th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f shor traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location Completed by Funeral Director 1 Yes 2 No MD BAUTIMORE 10e. Street and Number 10g. Citizen of What Country? USA and 2 should be filed within 72 hours after death with 2121 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian 11. Marital Status Black White etc Yes 2 No 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: BLACK 3 ₩ Widowed 4 □ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) PRIVATE HOUSEWIFE Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 CALLAWAY Department of Health ar Important: If item 27 is any injury or other trau DAUGHTER IONES Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Page 1 s 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) BAUTIMORE, MO LOUDON PARK 22. Name and Address of Facility VAUGHN GREENE PUNERAL SEVS PA 21. Signature Fig. ral S vice I censes YORK ROAD. BALTO 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Proviction Colon Cancer disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine to the Hospital or Attending Physician. The law requires that the death certificate be executed burial-tra Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 the as IF FEMALE use 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 morths?

1 Yes 2 No
9 Unknown for Month Day Pregnant at time of death ate has been signed by the a page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 1 Yes 2 No After this certificate 25. Was case referred to medical examiner?

1 Yes 2 No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) nt 11-50, (1-မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation Accident within 24 hours after deatl

To the Funeral Director;

completely filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0057465 115 Rajaph & MO 3/22/12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NSRAGARAKSY MD 2835 Smill) Baltomore MDZ1209 5 703 Smith AV

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day,

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Reg. No. 🤈 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ William Landon 2012 Russell 9:15P M March Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Harford Bel Air Sentor Bob Hooper House 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Min Director 1 🛛 M 2 🗆 F 93 212-01-5163 Yrs. July 27,1918 Maryland Usual Residence of Decedent 28a-f shov 10d. Inside City Limits 10a. State 10c. City, Town or Location must be notified at Director Dunda1k MD Baltimore 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö Funeral items 23a United States 21222 2626 Yorkway 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status the Medical Examiner Armed Forces?

1 Yes 2 No Black, White, etc ò þ 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 🙀 No Specify: If Yes, Give "natural", Completed 3 ▼ Widowed 4 □ Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than, Elementary/Secondary (0-12) College (1-4 or 5+) Steel Industry Inspector 10 Years 201 other Be Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) and Mental is marked o 2 Anna Sophia Finger pe Samuel William Landon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once, Eagle View Drive Bel Air, Maryland 21015 Gary R. Landon N Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1XX Burial 2 Cremation 3 Removal from State Baltimore, Maryland 3/26/2012 Øak Lawn Cemetery Other (Specify) 4 Donation 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. Sign 1 7922 Wise Ave. Dundalk, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate nterval Between Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Litter underlying Cause (Disease or injury that initiated events seathing in death) Lect. Examiner Due to (or as a consequence of): attending physician and Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day 5 Other (specify) Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ANDON Completed by Records, 1 🗌 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy Director: After this certificate or Attending Physician: director, 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be Division of Vital 2 No Other: 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 28a. Date of injury (Month, Day, Year) funeral Manner of Death 28c. Injury at work?
1 Yes 2 No 28b. Time of 28d. Describe how injury occurred iniurv 5 Pending Natural Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by 4 Homicide determined City or Town, State) within 24 hours a Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier In Michael Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1041 VALLEY RD TIMOMUM, MD 2003 DULANEY CRNP 2300 Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

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DHMH 17 Rev 06-2011

ORIGINAL

Colin Lutz		Please Type or Print in Black Indelible State of Maryland / Department				2 0944					
		1- For State Certificate		Reg.		4 0044					
Physicia Medical Exami		Decedent's Name (First, Middle,Last) Colin Lutz		2. Date of Death Month Da March 18, 20	ay Year 012	3. Time of Death 1617 hrs					
		4a. Facility Name (if not institution, give street and number) 500 Upper Chesapeake Drive	4b. City, Town, or Location of Death Harford Bel Air		4c. County of Death Harford						
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday 15-96-2704 1	y) If Under 1 Year If Under 24Hrs Months Days Hours Min		MM/DD/YYYY) 9. Birt 1964 Foreig Coi	hplace (State or n uniMaryland					
Maryland 28a-f show any Lat. ones.	or	Usual Residence of Decedent 10a. State	Edgewood		10d. Inside City Lim 1 Yes 2						
h the Maryland 3a or 28a-f sho	1 Director	10e. Street and Number Unkn.	10f. Zip Code 21040	10g.		Citizen of What Country? USA					
4 5 8 8	by Funeral	1 Never Married 2 Married Armed Forces? 1 Yes 2 No 13 Widowed 4 Divorced of Pates:	Was Decedent of Hispanic Origin? (Spif Yes, specify Cuban, Mexican, Puerto Yes 2 No specify:	Rican, etc.)	14. Race - American Indian, Black, White, etc. White						
5-0036 ted within 72 hours a fygiene. other than "natura the Medical Exami	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	odent's Usual Occupation (Give kind of v g most of working life. DO NOT use reti Drywall Installer	red)		ruction					
21215-0036 unld be filed within 7 Mental Hygiene. marked other than ie event, the Medica	8	17. Father's Name (First, Middle, Last) John L. Lutz	ten Surname) a L. Glenn								
MD 2 and 2 shoul saith and M cm 27 is m	٩	Rebecca H. White / Sister 200	illing Address (Street and Number or F 01 Highland Avenue, Bel A position (Name of cemetery,	Air, MD 2101	; City or Town, State, 5 Dc. Location - City or 1						
Baltimore, permit. Pages I au Departament of Hee Important: If ite		1 Burial 2 Cremation 3 Removal from State Chesap 4 Donation 5 Other Specify:	rother place) eake Crematory 3/2	23/2012	Beltsvi						
Physician		Dorota Marshall 23a. Part I. Enter the dispersion complications that caused the death. Do not ent	Name and Address of Facility Maryland Cremation Ser the mode of dving, such as cardiac or			ore, MD 21203					
/Medical Examiner		failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Cardiomegaly Due to (or as a consequence of):), ig		one of the original to	Between Onset and Death					
	ē	Sequentially list conditions, b									
urted 1d ransit	cal Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): d.									
O, be executed sician and burial - transi		▼ UNPENDED ▼ AMENDED 4b, 23a, pt.II,	27,per me,g926 4-4	-12 sm							
that the death certificate be executed ned by the attending physician and detached for use as the burial - transit		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 4 Pregnant at time of death 5 9 Unknown	Fetal death 3 Ectopic pregnar Other (Specify)		23d. Date of delivery Month Da	ay Year					
ires that the signed by	≦	Part II. Other significant conditions contributing to death but not resulting in the Chronic Alcohol Abuse	e underlying cause given in Part I.		co use contribute to the						
Division of Vital Records, P.O. To the Hospital or Attending Physician: The law requires that th within 24 hours after death. To the Funeral Director: After this certificate has been signed by completely filled in by the funeral director, page 2 should be detach.	Completed	25. Was case referred to medical	26.Place of Death (Check o	24a. Was an autopsy performed	prior to co death?	opsy findings available mpletion of cause of					
Vita hysician this cer	ě	examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ✓ ER/Outpatie	Tau .		idence 6 Other:						
ion of tending P (eath.	ation:	27. Manner of Death 1 X Natural 5 Pending 2 Accident Investigation 2	of Injury 28c. Injury at Work?	28d. Describe how i	injury occurred						
Divis	Certification:	3 Suicide 6 Could not be determined (Specify)	reet, factory, office building, etc.	28f. Location (Stree or Town, State)	t and Number or Rura	l Route Number, City					
Division of Vital To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifi Completely filled in by the funeral director,	edical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death oc (Check anly 2 Medical Examiner: On the basis of examination and/or investion and manner stated.	gation, in my opinion, death occurred at	the time, date and	place, and due to the	cause(s)					
	2	29b. Signature and title of certifier	29c. License number O.C.M.E.	Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Con	d. Date signed (Monti arch 19, 2012	h, Day, Year)					
	-	f LUNCLY TOUR MULLS 30. Name and address of person who completed cause of death (Item 23a) Pamela E. Southall, MD Assistant Medical Examiner 9	00 W. Baltimore Street, Baltim								
Sta	_	31. Date filed (Month, Day, Year) 32. Registrar's Signature		1016, IVID 2122.	<u> </u>						
Registr	ar	MAR 2 7 2012 Senus B. 1900									

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			Registrar 1. Decedent's Name (First, Middle, Last)	erillicate of Death	Reg. N	3. Time of Death			
	Physicia	_	India Louise Lemon		Month 23				
	Medic Examin	al .	4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	'	c. County of Death	٦		
	LXCIIIII	Ğ.	Gilchrist	Baltimore		N/A			
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	y) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Year)				
	Director		218-44-8608 1 □ M 2 ☒ F		03/04/19	42 Maryland			
	nd how at	'n	Usual Residence of Decedent USA 10a. State 10b. County 10c. City, Town or	Location		10d. Inside City Limits	٦		
	laryla 3a-f s ified	Director	MD N/A	Baltimore		1 ☐ Yes 2 ☐ No			
	or 28		10e. Street and Number	10f. Zip Code	10g. C	Citizen of What Country?	П		
	with s 23a ust b	Funeral	706 Allendale St.		U.S.A.				
	death item item		11. Marital Status 12, Was Decedent Ever in U.S. Armed Forces?	 Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto 	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.			
36	within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f sho er than matural Examiner must be notified at the Medical Examiner.	d by	1 Never Married 2 Married 1 Yes 2 XNo 1 Yes, Give 3 Widowed 4 Divorced Year or Dates	1 ☐ Yes 2 🔀 No Specify:		Specify: Black	- 1		
8	atura cal E	Completed	15. Decedent's Education 16a. De	cedent's Usual Occupation	16b.		71		
215	n 72 h an "n Medi	I I	(Specify only highest grade completed) (G.	ive kind of work done during most of work b. DO NOT use retired)		Kind of Business/Industry Itimore City blic Schools	η		
212	withir giene er th		2 years	Teacher	Pu		_		
Maryland 21215-0036	I be filed within 72 hours after death with the Maryland lental Hygiene. rked other than "natural", or items 23a or 28a-f show tic event, the Medical Examiner must be notified at	To Be	17. Father's Name (First, Middle, Last) Thomas Sessons Sr.		ie (First, Middle, Maidel 1 Louise	•			
ryla	ould be find Mental marked matic ev	-					\dashv		
Mai	a is			ailing Address (Street and Number or Rur 09 Barbara Ave.,					
	1 and 2 s of Health item 27 other tra		20a. Method of Disposition 20b. Place of Di	sposition (Name of		Location - City or Town, State	۲		
non	age 1 ent of nt: If i			wn Cemetery 03/3	30/12 Ba	ltimore,MD			
Baltimore,	permit. Page 1 an Department of He Important: If iten any injury or oth						٦		
m	an m ber		Wietrich W. Williams	27 November of Fally own 2140 N. Fulton 7	ve.; Bal	timore, MD21217	_		
			23a. Part 1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.	enter the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between	i		
ada a	Physician/		Immediate Cause (Final disease or condition	in intimu		nset and Death	Щ		
	Medical Examiner		resulting in death) Due to (or as a consequence of):	1-21-0					
	LXammer	<u>_</u>	Se pentially list conditions b.		weeks	-			
	ed sit	Examine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury						
	be executed sician and burial-transi		that initiated events resulting in death) Last C. Due to (or as a consequence of):				П		
0	is that the death certificate be executed igned by the attending physician and be detached for use as the burial-transit	dical	d						
Box 68760	ificate ng phy as th	Med	IF FEMALE:						
<u>ن</u>	death certificat ne attending ph ed for use as tl	an/l	23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death	3 Ectopic pregnancy		23d. Date of delivery Month Day Year	Ŷ		
	the at	Physician/Me	1 Yes 2 No 9 Unknown Yes 2 No 9 Unknown	5 U Other (specify)		Month Day real			
P.O.	at the		Part II. Other significant conditions contributing to death but not resulting in the	he underlying cause given in Part I.	23e, Did tobacco	o use contribute to the cause of death?			
	e s o	d by			1 🗆 Yes	2 No 3 Probably 4 Unknown	1		
ord	require been si should	lete			24a. Was an	24b. Were autopsy findings available			
of Vital Records,	sician: The law of certificate has be lirector, page 2 s	Completed			autopsy performed? 1 \(\sum \) Yes 2	prior to completion of cause of death? No 1 Yes 2 No			
al H	an: Th tificat tor, p	l o	25. Was case referred to medical	26. Place of Death (Chec		110 100 12 110			
Vit	Physician: this certific ral director,	To B	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outp.	atient 3 DOA Other: 4 Nursing H	ome 5 🗆 Residence	6 Other (Specify) WOSDLY			
of	frer thundera		27. Manner of Death 1 Natural 5 Pending 28a. Date of injury (Month, Day, Year) 28b. Tim	ry work?	28d. Describe how inj	ury occurred			
ion	Attending or death. ector: After by the fune	ĘĘ	Accident Investigation Solicide 6 Could not be 28e. Place of Injury - At home, farm	M 1 Yes 2 No	29f Langting (Street)	and Number or Rural Route Number,			
Division	l or Atten after deat Director:	Certificate:	4 Homicide determined building, etc. (Specify)	, street, lactory, office	City or Town, Sta				
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Medical	29a. Certifier Certifying Physician: To the best of my knowledge, de	ath occurred at the time, date and place,	and due to the cause(s)) and manner as stated.			
	in 24 h	Med	(Check 2 Medical Examiner: On the basis of examination and/or in only one) 3 Certifying Nurse Practitioner: To the best of my knowle	rvestigation, in my opinion, death occurred a dge, death occurred at the time, date and p	at the time, date and pla lace, and due to the cau	ice, and due to the cause(s) and manner state use(s) and manner as stated.	ed.		
	To the within 2 To the comple	-	29b. Signature and title of certifier	29c Lisense number		Date signed (Month, Day, Year)			
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)			30. Name and address of person who completed cause of death (Item 23a) (Type 130. Name and address of person who completed cause of death (Item 23a) (Type 130. Name and address of person who completed cause of death (Item 23a) (Type 130. Name and address of person who completed cause of death (Item 23a) (Type 130. Name and address of person who completed cause of death (Item 23a) (Type 130. Name and address of person who completed cause of death (Item 23a) (Type 130. Name and address of person who completed cause of death (Item 23a) (Type 130. Name and address of person who completed cause of death (Item 23a) (Type 130. Name and address of person who completed cause of death (Item 23a) (Type 130. Name and address of person who completed cause of death (Item 23a) (Type 130. Name and address of person (Item 23a) (Type 130. Name and address of person (Item 23a) (Type 130. Name and address of person (Item 23a) (Type 130. Name and address of person (Item 23a) (Type 130. Name and Address of person (Item 23a) (Type 130. Name and Address of person (Item 23a) (Type 130. Name and Address of person (Item 23a) (Type 130. Name and Address of person (Item 23a) (Type 130. Name and Address of person (Item 23a) (Type 130. Name and Address of person (Item 23a) (Type 130. Name and Address of person (Item 23a) (Type 130. Name and Address of person (Item 23a) (Type 130. Name and Address of person (Item 23a) (Type 130. Name and Address of person (Item 23a) (Type 130. Name and Address of person (Item 23a) (Type 130. Name and Address of person (Item 23a) (Type 130. Name and Address of person (Item 23a) (Type 130. Name and Address of person (Item 23a) (Type 130. Name and Address of person (Item 23a) (Type 130. Name and Address of person (Item 23a) (Type 130. Name and Address of person (Item 23a) (Type 130. Name and Address of person (Item 23a) (Type 130. Name and Address of person (Item 23a) (Type 130. Name and Address of person (Item 23a) (Type 130. Name and Address of person (Item 23a) (Type 130. Name and Address of person (Item 23a)	6701 N Clan	1CLS ST	JONSON MD			
	Sta	te	31. Date filed (Month, Day, Year) 32. Projectics Signature		1				
	Registr		MAR 2 7 2012 June 3.	barles					

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month Day Physician/ 2012 Shirley 13 6 Medical Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town or Location of Death **Examiner** 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 216–32–6277 6. Sex **Funeral** (Month, Day, Year) Days Hours Min 75 Director 1 □ M 2**X** MD Usual Residence of Dec 28a-f show 10d. Inside City Limits 10a. State 10b. Count 10c. City, Town or Location be notified at Director Baltimore MD N/A 1 XXYes 2 □ No 10g. Citizen of What Country? 10e. Street and Number 1163 Sargent Street 10f. Zip Code Ь 21223 Funeral 23a other traumatic event, the Medical Examiner must 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Was Decedent Ever in U.S. 11 Marital Status Black, White, etc. Armed Forces?
1 ☐ Yes 2 ☐ Yo 6 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 Yes 2 XXo Specify White If Yes Give Specify: Completed 3XXWidowed 4 □ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Il Hygiene. College (1-4 or 5+) Elementary/Secondary (0-12) Own Home Homemaker 8 Be 18. Mother's Name (First, Middle, Maiden Surname)
Florence Koch 17. Father's Name (First, Middle, Last) and Mental ပ Ringle Charles K. 19a. Informant's Name/Relationship (Type, Print)
Billy K. May / Son 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1219 Chesaco Avenue, Roseda Le MD 21237 0 permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 Cremation 3 Removal from State Ardent Crematory 3/23/2012 Hanover Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Euneral Service Licensee Victor P. Doda Charles L. Stevens Funeral Home, Inc. 1501 E. Fort Avenue, Baltimore Maryland 21230 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final disease or condition Severe CORD Physician/ Medical resulting in death) Due to (or as a consequence of): Examiner UPRE Depadence Tobacco Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) death certificate be executed the burial-transit Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Be Completed by Physician/Medical Box 68760 IF FFMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death 3 Ectopic pregnancy
Pregnant at time of death 5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Dav Pregnant at time of death the Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 2 🗷 1 Yes Yes the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 No Other: မ 1 \sum Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: To the Hospital or Attending Payithin 24 hours after death.

To the Funeral Director: After work?
1 Yes 2 No 1 Natural iniury 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide filled in by determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title 29c. License number 20065570 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Deelyn Hones MD Blvd Beltmore MD 21230 1111 Washington

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Mor

12-02266 Eheron Melton		Please Type or Print in Black Indelible Ink. Ensure All Copie State of Maryland / Department of Health and Mental Hy		ible.				
		1- For State Certificate of Death	Reg. No. 2012 0945					
Physicia Medical Examir	ın/	1. Decedent's Name (First, Middle,Last) Theron Melton	Date of Death Month	n Year	3. Time of Death			
.)		4a. Facility Name (if not institution, give street and number) Brinton Woods Nursing Home 4b. City, Town, or Location of Death Baltimore	March 17,	4c. County of Death	0000 1113			
Funeral Director	10	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 215-76-5761 TM 2 F 55 Yrs.		1956 Foreig	hplace (State or Mary land untry)			
Aaryland 28a-f show any 18 0000.	Director	Usual Residence of Decedent 10a. State	10	g. Citizen of What Cour	10d. Inside City Limits 1 X Yes 2 No			
th with the N ems 23a or t be notified	Funeral Dir	3112 E.Northern Parkway 21214 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Sp. 1 X Never Married 2 Married 2 Married 2 Married 12. Was Decedent Ever in U.S. 14. Was Decedent of Hispanic Origin? (Sp. 15. Never Married 2 Married 14. Never Married 15. Never Married 16. Never Married 16. Never Married 17. Never Married 17. Never Married 17. Never Married 17. Never Married 18. Never Married 18. Never Married 18. Never Married 19. Never Married 19. Never Married 19. Never Married 19. Never Married 19. Never Married 19. Never Married 19. Never Married 19. Never Married 19. Never Married 19. Never Married 19. Never Married 19. Never Married 19. Never Married 19. Never Married 19. Never Married 19. Never Married 19. Never Married 19. Never Married 19. Never Married 19. Never Married 19. Never Married 19. Never Married 19. Never Married 19. Never Married 19. Never Married 19. Never Married 19. Never Married 19. Never Married 19. Never Married 19. Never Married 19. Never Married 19. Never Married 19. Never Married 19. Never Married 19. Never Married 19. Never Married 19. Never Married 19. Never Married 19. Never Married 19. Never Married 19. Never Married 19. Never Married 19. Never Married 19. Never Married 19. Never Married 19. Never Married 19. Never Married 19. Never Married 19. Never Married 19. Never Married 19. Never Married 19. Never Married 19. Never Married 19. Never Married 19. Never Married 19. Never Married 19. Never Married 19. Never Married 19. Never Married 19. Never Married 19. Never Married 19. Never Married 19. Never Married 19. Never Married 19. Never Married 19. Never Married 19. Never Married 19. Never Married 19. Never Married 19. Never Married 19. Never Married 19. Never Married 19. Never Married 19. Never Married 19. Never Married 19. Never Married 19. Never Married 19. Never Married 19. Never Married 19. Never Married 19. Never Married 19. Never Married 19. Never Married 19. Never Married 19. Never Married 19. Never Married 19. Never Married 19. Never Ma		USA 14. Race - Ameri White, etc.	can Indian, Black,			
irs after deal ural", nr it	6	1 Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year or Dates: 15 Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of w		Specify: Bla				
036 ithin 72 hounne. Ir than "mat Aedical Exa	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) 1 2th grade Unemployed						
	å	17. Father's Name (First, Middle, Last) Robert Melton 18. Mother's Name Virgini 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or R	a Syke	s	Zin Code)			
re, MD 2 shot Health and I fitem 27 is a traumatic		Emmanuel Melton/Brother 3112 E.Northern Pk 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery,	wy.Bal	. 21 21 4 Town, State				
Baltimore, permit. Pages 1 a Department of the Important: If it in injury ar other timing or other the injury ar other the injury ar other the injury ar other the injury ar other the injury ar other the injury ar other the injury ar other the injury ar other the injury ar other the injury ar other the injury ar other the injury ar other the injury are other the injury are other the injury are other the injury are other the injury are other the injury are other the injury are other the injury are other the injury are other the injury are other the injury are other the injury are other the injury are other the injury are other the injury are other the injury are other the injury are other the injury are other the injury are other the injury are other the injury are other the injury are other the injury are other the injury are other the injury are other the injury are other the injury are other the injury are other the injury are other the injury are other the injury are other the injury are other the injury are other the injury are other the injury are other the injury are other the injury are other the injury are other the injury are other the injury are other the injury are other the injury are other the injury are other the injury are other the injury are other the injury are other the injury are other the injury are other the injury are other the injury are other the injury are other the injury are other the injury are other the injury are other the injury are other the injury are other the injury are other the injury are other the injury are other the injury are other the injury are other the injury are other the injury are other the injury are other the injury are other the injury are other the injury are other the injury are other the injury are other the injury are other the injury are other the injury are other the injury are other the injury are other the injury are other the injury are other the injury are other the injury are other the injury are other the injury are other the injury are other the in		1 Serial 2 Cremation 3 Removal from State Parkwood Cemetery 03-4 Donation 5 Other Specify: 21. Significant Service Licensee 22. Name and Address of Facility Chause 4210 Belair Rd.			,Maryland eralHome			
	-	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or			206 Approximate Interval			
Physician \/Medical =xaminer		failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a Atherosclerotic Cardiovascular Diseas Due to (or as a consequence of):		st, show, or heart	Between Onset and Death			
	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last consequence of:						
execu an and	g		ne,g927	5-11-12 sm				
Box 68760, he death certificate be executed by the attending physician and hed for use as the burial - transit		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (Specify) 9 Unknown	псу	23d. Date of delivery Month D	ay Year			
P.O es that to igned by	É	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Cerebral Palsy, chronic renal disease, pneumonia		acco use contribute to t				
Division of Vital Records, P.O. rial ar Attending Physician: The law requires that the reafter death. al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach	Completed		24a. Was ar autopsy perform 1 Yes 2	y prior to coned? death?	opsy findings available completion of cause of S			
Vital ysicians this certif	o Be	25. Was case referred to medical examiner? 1 Ves 2 No Check of Death (Check of Death (Check of Death) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other 4 Nursing		esidence 6 Other				
Jing P	ation: T	1 X Natural 5 Pending (Month, Day, Year) 1 Yes 2 No	28d. Describe ho	w injury occurred				
hou ner	Certification:	Suicide determined (Specify)	or Town, Sta					
To the H within 24 To the Fi completel	edica	Check only 2 Medical Examiner: On the bast of my knowledge, death occurred at the time, date and place, and of one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at and manner stated. 29b. Signature and title of certifier 29c. License number	the time, date ar		cause(s)			
		O.C.M.E. 30. Name and rodress of person who completed chuse of death (Item 23a)		March 21, 2012				
, I		Melissa Brassell, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore	e, MD 21223	3				
State 31. Date filed (Month, Day, Year) 72. Registrar's Signature Registrar NAR 2.7 2012 12. Registrar's 2. Apart 1.								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Audrey Fisher Martin MARCH 26 2012 01:49 PM Medical Facility Name (if not institution, give street and number Examiner City, Town, or Location of Death 4c. County of Death HOSPITAL SALTIMORE n/a 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Year If Under 24 Hrs **Funeral** 220-18-2794 Director 1 □ M 2 💢 F Maryland April 2,1926 10b. County 10c. City, Town or Location ms 23a or 28a-f sho must be notified at Director Baltimore 1 🗌 Yes 2 🙀 No Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 213 Sanford Ave. death with 21228 USA iral", or items a 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Completed by 1 Never Married 2 Married 1 and 2 should be filed within 72 hours after of Health and Mental Hygiene.
item 27 is marked other than "natural", or other traumatic event, the Medical Examir 1 Yes 2 If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify. 3 ☐ Widowed 4 ☐ Divorced Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Secretarial Social Security Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ferdinand William Fisher Anna Marta Konig 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frank J.Martin,III/son 213 Sanford Ave.Catonsville, Maryland 21228 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Department of H Important: If ite any injury or ot cemetery, crematory or other place 1 Burial 2 X Cremation 3 Removal from State Metro Crematory, Inc. 4 Donation 5 Other (Specify) 3/27/2012 Baltimore, Maryland ature of Funeral Service License Stephanie Custer 22. Name and Address of Facility Cremation Society of Maryland, Inc 299 Frederick Road Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one caus Immediate Cause (Final ARDIOGENIC .Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) IVER FAILURE Cause (Disease or injury that initiated events resulting in death) Last physician and the burial-trans attending physician Physician/Medical INFECTION RACT certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ or Attending Physician: The law requires that the death in the past 12 month 1 ☐ Yes 2 ☑ No Pregnant at time of death Month Dav Year 9 🔲 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Certificate: To Be Completed by 1 Yes 2 No 3 Probably 4 Vunknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed within 24 hours after death.

To the Funeral Director: After this certificate I 1 🗌 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 Yes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28h Time of 28c. Injury at 28d. Describe how injury occurred 1 Matural work? 1 ☐ Yes 5 Pending 2 🗌 No Investigation Could not be Accident 3 Suicide 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined To the Hospital Medical 29a Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number P 25487 MARCH 26 30. Name and address of person who mpleted cause of death (Item 23a) (Type, Print) S. CATON AVENUE, BALTIMORE, MD SEHICKI 900

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ March 24 Elizabeth McKinley , ŽÕ12 5:10 a M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Montgomery Holy Cross Hospital Silver Spring 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Birthplace (State or Foreign Country) 578-62-9329 **Director** 1 🗆 M 2 💢 F Dec. 18,1948 63 DC or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Montgomery 1 🗌 Yes 2 💢 No Silver Spring 10e. Street and Number items 23a or ner must be n ō 10f. Zip Code 10g. Citizen of What Country? Funeral 214 Dale Drive 20910 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or iten 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 X Married 1 ☐ Yes 2 ሺ No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Completed 3 Widowed 4 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) I Hygiene. Elementary/Secondary (0-12) 12 College (1-4 or 5+) Secretary State Department of Health and Mental Hygie f item 27 is marked other r other traumatic event, th Be 17. Father's Name *(First, Middle, Last)* unknown 18. Mother's Name (First, Middle, Maiden Surname) unknown မ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) if of Health a Mario McKinley/husband 214 Dale Drive Silver Spring, MD. 20910 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Donation ŏ permit. Page Department of Important: If any injury or once. Metro Crematory, Inc. 3/26/2012 Baltimore, Maryland 21. Singure of Ineral Service Licenses Stephanie Custer 22. Name and Address of Facility Cremation Society of MD. Inc. 299 Frederick Road Baltimore, Maryland 21228 23a. Part 1. Exter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ Onset and Death Pneumonia disease or condition resulting in death) Medical Due to (or as a consequence of): Aspiration and community acquired Examiner Sequentially list conditions, Due to (or as a consequence of): dury leading to in medicause. Enter Underlying Cause (Disease or injury Exami physician and the burial-transit Advanced Multiple Sclerosis that initiated events resulting in death) Last Physician/Medical requires that the death certificate be Box 68760 as the attending IF FEMALE: nse yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death Ectopic pregnancy for in the past 12 months? 5 Other (specify) Month Pregnant at time of death Day 1 ☐ Yes 2 🔀 No 9 ☐ Unknown 9 Unknown P.0. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 😾 Unknown page 2 should After this c_rtificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician: The law autopsy performed?

1 Yes 2 No 1 🗌 Yes 2 \square No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 X No dire ည 1 Yes 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 X Natural 5 Pending 24 hours after death.

Funeral Director: At letely filled in by the fu Accident 1 Yes Investigation Suicide 6 Could not be 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office bullding, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) within 24 hours a
To the Funeral D Medical 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D0064100 Min. March 25,2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1500 Forest Glen Rd.Silver Spring, MD.20910 Dr.Smitha Bhikkaji,

DHMH 17 Rev 06-2011

State

Registrar

31. Date filed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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	Physicia	n/	1. Decedent's Name (First, Middle, Last)				•	2. Date of D	eath	6.0	3. Time of Death				
	Medic Examin	al	Paul Mosny 4a. Facility Name (if not institution, give street and number)		4b. 0	City Town, or	Location of De	Marc	_	Day Year 20, 2017					
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	aryland ka-f sh ified al	ecto	MD Washington	10c. City, Town o							10d. Inside City Limits 1 Yes 2X No				
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980	filed within 72 hours after death with the Maryland tral Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	ρ	1 Never Married 2 Married 3 Widowed 4 XDivorced Armed Forces? 1 Yes 2X If Yes, Give Year or Dates.		If Yes, s	specify Cubar es 2 XNo	n, Mexican, Pu	erto Rican, etc.)		Black, Whi	Black, White, etc.				
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	2 ± 2 ± 5		Karoline Shair/daughter	1	_			ngton, MA	-		,p Code)				
Baltimore,	permit. Page 1 and Department of Heal Important: If item: any injury or other once.		20a. Method of Disposition 1 ☐ Burial 2 【**X*Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		crematory	or other place		Date 03/26/12	1	Location - City o					
Balt	permit. Page Department o Important: If any injury or once.		21. Signature of Funeral Service-Licensee	MO1251	^{22, Nam} Soing Bever	e and Addres Home 1y L.	s of Facility Cremat Heckro	ion Servi Ete, P.A.	.ce Cl	P.O. Bo arksvill	x 784 e, MD 21029				
ï	Physician/ Medical		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of): PRSTEWS M. RATSILIS PREMIUM 1.4												
and a															
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260	ate be physici the bu	edical	d												
Box 687	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and ral director, page 2 should be detached for use as the burial-transi	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown IF FEMALE: 23c. If yes, outcome of the past 12 months? 4 □ Pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant	2 Fetal death	3 Ecto: 5 Othe		у			23d. Date of de Month	elivery Day Year				
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	To the Hospital or Attending F within 24 hours after death. To the Funeral Director, After completely filled in by the funer	Medical	29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examiner: On the basis of examiner: On the basis of examiner: To the	amination and/or ir	nvestigation	i, in my opinio	n, death occurr	ed at the time, date	and pla	ce, and due to the	cause(s) and manner stated.				
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)		30. Name and address of person who completed cause of de		pe, Print)	MIST	0149 D. 98	O ILA	, Com	CTOVER	. MD				
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2012 A^{M} 9:55 Grace Mary McKim March Medical 4a. Facility Name (if not institution, give street and number, **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore <u>Gilchrist Hospice Center</u> Towson Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Months Hours Min. Director 196-20-2652 83 1 □ M 2**X X**F Pennsylvania March 12,1929 Usual Residence of Decedent 28a-f shov 10a. State r than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Stewartstown PA York 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 809 South Marshview Road 17363 United States of America 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2XX No Specify: Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working and Mental Hygiene. is marked other than life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Own Home Homemaker 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Ferdinand Heney Mary Myers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 4808 Hoffmenville Road, Manchester, Maryland 21102 Christine S. Winemiller-Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place)

Evans Funeral Chapel and Chamation Services — Belair 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State March 27,2012 Forest Hill, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Evans Funeral Chapel and Cremation Services-Monkton 16924 York Road, Monkton, Maryland 21111 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ Netastas disease or condition resulting in death) Medical Due to (or as a consequence of **Examiner** Sequentially list conditions, Directo (or as a nonsequence of) cause. Enter Underlying Cause (Disease or injury Examin inding physician and use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown ρ Month Dav Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Records, or Attending Physician: The law requires Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has perform death? Yes 2 No 1 🗌 Yes Division of Vital 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? Other: ျပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) HOSA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending ours after death.

neral Director: A

filled in by the fu 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a

To the Funeral C

completely filled Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only or Sertifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signatu

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Registrar

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of person who completed cause of death (Item 23a) (Typer Print) Strabeau, 6701D. Clarles St. & 405, Balthouse, MS 21204

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Month 01:05 AM Muscante Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** ALNES tOSPITAL BALTIMORE CAINT If Under 1 Year | If Under 24 Hrs. Social Security Numbe 7. Age (In yrs, last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day Year) 1921 Mary Land 1 □ M 2**X**) F Days Hours Director Nov. 219-22-3454 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10b. County 10a. State filed within 72 hours after death with the Maryland al Hygiene. 10c. City. Town or Location 10d. Inside City Limits Director MD Baltimore Catonsville 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6267 Gillston Park Road 21228 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 XNo Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 X Married Completed by Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify White Specify 3 Widowed 4 Divorced Year or Dates event, the Medical Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Contract Coordinater Westinghouse Be 17. Father's Name (First, Middle, Last) 18. Mother's Name *(First, Middle, Maiden Sumame)* Viola Barnhardt Edgar Madden permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anthony Joseph Muscente-Husband 6267 Gillston Park Road Catonsville Maryland 21228 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Loudon Park Cemetery Mar.27,2012 | Baltimore Maryland 21. Snature F F eral Service Licensee 22. Name and Address of Facility Ambrose Funeral Home Inc. 1328 Sulphur Spring Road Arbutus Maryland 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Provincian/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Pregnant at time of death Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 X Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy 1 ☐ Yes 2 ☐ No **Division of Vital** Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 2 **N**0 Hospital Other: ြု 1 Tyes 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 🖔 Natural iniury work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State Medical 🖟 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier

Registrar
DHMH 17 Rev 7/2009

State

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MD 21229

Baltimore

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32. Registrar's Signature

→ Hirut Gebrewold, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GEBRENOL

31. Date filed (Month,

MAR 2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene = State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 25, 2012 Physician/ MARCH 6:29 P M RALPH FRANCIS MCCOY Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** ANNE ARUNDEL BALTIMORE WASHINGTON MEDICAL CENTER **GLEN BURNIE** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday If Under 1 Year If Under 24 Hrs. **Funeral** Min. Hours Director 216.36.8968 1 XX 2 - F 71 AUGUST 25, 1940 Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 XXNo **GLEN BURNIE** ANNE ARUNDEL 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2 FERNGLEN AVE. 21061 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Apped Forces? 1 Never Married 2 Married Black, White, etc. þ 1 Yes XX No Specify: If Yes, Give Specify: 3 Widowed 4 Divorced Completed WHITE Year or Dates. 1960-62 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) **PAINTER** 10 Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ MARY FRANCES MIDDLECOFF JOHN MCCOY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16363 CAMALO DR. MT AIRY, MD 21771 STEPHEN MCCOY SON 3altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 D Burial 2XX Cremation 3 D Removal from State BAYVIEW CREMATORY INC 3.26.2012 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) Sig alund of Funeral Service Line (see 22. Name and Address of Facility
FINK FUNERAL HOME, P.A.
426 CRAIN HWY SW GLEN BURNIE, MD 21061 K. CRECORY AUNK M01148 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ LOSTrideum disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examiner Due to for as a consequence of cause. Enter Underlying Cause (Disease or injury the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? 1 ☐ Yes 2 ☐ No Pregnant at time of death 1 Yes 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by cell cancer of Lung with metastaris to bidin 1 yes 2 No 3 Probably 4 Hunknown tibrillation with rapid ventricular 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 WO 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital Other: မ 1 🗌 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: (Month, Day, Year) 1 Natural 5 Pending 1 Yes 2 No ☐ Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide determined within 24 hours a To the Funeral D the Hospital Medical 29a. Certifier 1 🖵 estrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Gentlying Nurse Practitioners To the best of my individue, death control at the time, date and plane, and due to the cause(s) and manner as state 29b. Signature and title of certifier 29c. License number D6668123 Merch 25, 2012 Wace 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Novacia: 301 Hospital Dr. Glen Burnie MD 21061. 31. Date filed (Month, Day, Year)

DHMH 17 Rev 06-2011

Registrar

	State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2012 09457														
			Registrar 1. Decedent's Name (First, Middle, Last)	Jertificate of Death											
E	Physicia Medic		Mary Gilda Marques		2. Date of Death March	2 ¹ 2012	3. Time of Death 9:45 A M								
	Examir	ner	4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	h	4c. County of Death									
	F		Spring House Assisted Living 5. Social Security Number 6. Sex 7. Age (In yrs. last birth)	Bethesda (av) If Under 1 Year I If Under 24 Hrs.	. 8. Date of Birth	1	Montgomery								
	Funeral Director		022-07-2981 1 □ M 2XXF 94 Y	Months Days Hours Min.	(Month, Day, Y	(ear) 9. Birth Cou	intry)								
	nd how at	٦	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town	or Location	ocation 10d. Inside City I										
	Maryla 28a-f s otified	irecto	MD Montgomery	Bethesda			1 🗆 Yes 2 No								
	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at ance.	Funeral Director	10e. Street and Number 4925 Battery Lane	10f. Zip Code 20814	10	10g. Citizen of What Country? United States									
စ္တ	ter death , or item iminer n	by Fui	11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 No If Yes, Give	13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	pecify Yes or No- o Rican, etc.)	14. Race - Ameri Black, White,	, etc.								
-003	nours a latural' ical Exa	eted	Year or Dates. 1945-50	1 ☐ Yes 2 🎇 No Specify:			mery place (State or Foreign achusetts 10d. Inside City Limits 1 Yes No ntry? ates can Indian, etc. White dustry es Code) own, State e, MD O910 Approximate Interval Between Onset and Death onset and Death pay Year pably 4 Unknown osy findings available mpletion of cause of 2 No ED LIVING								
Maryland 21215-0036	thin 72 h ene. than "n i he Medi i	Completed by	(Specify only highest grade completed) Flementary/Secondary (0-12) College (1-4 or 5-)	Recealts solar occupation Give kind of work done during most of wor fe. DO NOT use retired) dical Doctor	rking	6b. Kind of Business/I	ndustry								
nd 2	filed wi al Hygid d other vent, t	iden Surname)													
nyla	d Ment marked matic e	은	Sylvio Marques 19a. Informant's Name/Relationship (Type, Print)	Etelzi		Soar									
, Ma	nd 2 sho ealth an n 27 is er trau			Mailing Address (Street and Number or Ru. 75			Code)								
Baltimore,	age 1 ar ent of He nt: If iter y or oth		1 ☐ Burial 2 XX Cremation 3 ☐ Removal from State cemetery,	Disposition (Name of crematory or other place)		Oc. Location - City or T Beltsvill									
Balti	permit. P Departm Importa any inju		21. Signature of Funeral Service Deensee M00382	eake_Crematory 03/3 22 Name and Address of Eacility Rapp Funeral and	Cremation	Services	-								
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اسمه	Ph, i i Medical		Immediate Cause (Final disease or condition resulting in death) a. ATHEROSCLEROTIC CEREBROVASCULAR DISEASE Due to (or as a consequence of):												
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ds,	requires that the der been signed by the s should be detached	ted b			1 ☐ Yes	2 X No 3 □ Pro	bably 4 🗆 Unknown								
Records,	or Attending Physician: The law requires after death. Jirector: After this certificate has been sign in by the funeral director, page 2 should by	Completed			24a. Was an autopsy performe	prior to co	opsy findings available ompletion of cause of								
a	ian: T rtifica stor, p	Be C	25. Was case referred to medical examiner?	26. Place of Death (Chec	1 Yes 2xt	X No I □ Yes	2 LJ No								
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Division of Vital	al or Attences after death		3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm building, etc. (Specify)	, street, factory, office	28f. Location (Stree City or Town, S	et and Number or Rura State)	l Route Number,								
	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	Medical	29a. Certifier (Check only one) 1	nvestigation, in my opinion, death occurred a	at the time, date and	place, and due to the ca	use(s) and manner stated.								
-	To the within 2 To the comple		29b. Signature and title of certifier	29c. License number H45839		Date signed (Month, IARCH 23, 2									
D .	+1		30. Name and address of person who completed cause of death (Item 23a) (Ty Gary E. Raffel, DOFACP, 6413 W. Ce		thesda, M	D 20814									
	Stat Registra		21 Date filed (Month Day Year)	barles											
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DHMH 17 Rev 06-2011

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Physician		1. Decedent's Name (First, Middle, L FRANK PAUL MIKA			Cer	incate of L	Jeaur	2. Date		Day Y	/ear	3. Time of Death	
Medica Examine	ı -	4a. Facility Name (if not institution, gi		per)		4b. City, Town, o	r Location	Marc		4c. County of	12	2:40 P M	
Funeral Director		220 50 4153	Sex 7	7. Age (In yrs. Ia	as <i>t birthday)</i> Yrs.	Nottin If Under 1 Year Months Days			th, Day, Yea	ar)	* **		
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with the M	Funeral Director	10e. Street and Number 4401 Lobelia R	đ		occing.	10f. Zip Code	36		10g		Citizen of What Country? U.S.A		
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Baltimore, Maryland 21215-0036 Dermit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mential Hygiene. Important: If item 27 is marked other than "natural", o my hijury or other traumatic event, the Medical Exampres.	completed by	15. Decedent's (Specify only highest see Elementary/Secondary (0-12)	Education (grade completed) College (1-4)	,	(Give k life. DC	ent's Usual Occup ind of work done of NOT use retired) .T. Serv	during mo	st of working		b. Kind of Business/Industry			
yland 2 Ind be filed w Mental Hyg Barked othe attic event,	0	7. Father's Name (First, Middle, Last Victor Mikanow	10. Mother 3 Marile (First, Middle, Marger Surfame)										
Mar nd 2 shou lealth and m 27 is m		19a. Informant's Name/Relationship Josephine An	**		8800	Walther		per or Rural Route N Parkvill	-		e, Zip Coo	de)	
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of Vital Physician: this certificated director		examiner? 1 Yes 2 No 7. Manny of Death	Hospital: 1	patient 2 🗆 E	ER/Outpatient 28b. Time of	3 🗆 DOA Othe	er: 4 🗆 N	ursing Home 5			Specify)		
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Di To the Hospital Within 24 hours To the Funeral I completely filled Medical ((Check 2 Medical Examonly one) 3 Certifying Nu	niner: On the basis	of examination to the best of m	and/or investig y knowledge, o	gation, in my opinio leath occurred at the 29c. License	n, death o ne time, da number	ocurred at the time, of the and place, and du	late and pla e to the cau 29d. I	ace, and due to use(s) and manr Date signed (M	the cause ner as stat looth, Day	, Year)	
6 27	3	Name and address of person who	completed cause	of death (Item :	23a) (Type, Pri	050	209	ZIO TIM] 3	3/26/	201	Z	
State	3	1. Date filed (Month, Day, Year)	10	istrar's Signatu		MION C	مهر	LIU IIM	ONIL	em, n	IV Z	21095	
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Brian Raiph Moe		1- For State Registrar		ate of Maryla		rtificate of		and M		R	teg. No.	201	2 0945		
Physicia Medical Exami		Decedent's Nam	e (First, Middle		Ralph M	oallar				2. Date of Dea Month March 19		Year	3. Time of Death 1048 hrs		
)		4a. Facility Name (11601 Rock		n, give street and nu	ımber)	oener	4b. City, Tow Rockville		ion of Death		4c. (County of Dear	th		
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MD 21215-0036 12 should be filed within 7 th and Mental Hygiene. 127 is marked other than umartic event, the Medical	品	Robert Moeller Delphine Cocash										Cocash	- Zin Code)		
MD 2 12 shoul th and N 127 is m umatic	٩	Shaun Mo	Shaun Moeller / Son 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 3835 West Lombard Street, Apt. 3, Baltimore, MD 21201												
Baltimore, MD permit. Pages I and 2 sh Deartment of Health and Laportant: If item 27 is injury or other traumat			Cremation	3 Removal fr		Place of Dispos crematory or oth	ner place)	,	'	Date	20c. Lo	cation - City o			
Baltimore, permit. Pages 1 a Department of He Important: If ite	ł	4 Donation 5 21. Signature of Fu	Other Sponeral Service I		1	11	ame and Add	dress of Fa	cility	4/2012	<u></u>		ille, MD		
Physician	\dashv	Dorota Marshall													
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Division To the Hospital or Attendia within 24 hours after death. To the Funeral Director: /	Certification:	3 Suicide 4 Homicide		not be 28e. Place	e of Injury - At ho Lightrail Tr		t, factory, off	ice building		or Town, S	State)	Number or Ru Rockville, M	ural Route Number, City		
To the Hospital within 24 hours To the Funeral completely filled	edical	- 🖳	Medical Exam	ysician: To the bes niner:On the basis of and manner s	of examination a										
	Σ	29b. Signature and	m M	King	TRun	T. S.	[.C.M.E.	OCME			te signed <i>(Ma</i> 1 20, 2012	nth, Day,Year)		
		Name and addre Theodore M		who complete was MD. Assista	e of de in (Item nt Medical E		900 W. Ba	ltimore	Street, Ba	ltimore, MI	21223	3			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 0325M MAP 20 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Columbia Howard Howard County General Hospital Birthplace (State or Foreign Country)
 Illinois Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth **Funeral** (Month, Day, Year) 02/09/1956 Days Director 1 M 2 □ F 215-82-7814 56 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10b. Count 10a. State 10c. City, Town or Location Director 1 X Yes 2 No Columbia MD Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21044 **USA** 5009 W. Durham Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Marital Status Armed Force Black, White, etc. þ 1 Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 1 Yes 2 X No If Yes, Give Specify Completed 3 Widowed 4 Divorced White Year or Dates. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) N/A Did Not Work Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ျ Jean Dickson David Matzke 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 754 Fairhaven Road, Tracys Landing, MD 20779 Lynn Elizabeth Strauss / Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date □ Burial 2 X Cremation 3 □ Removal from State 4 Donation 5 Other (Specify) 3/25/2012 Beltsville, MD Chesapeake Crematory . Signature of Funeral Service Licenses Maryland Cremation Services, PO Box 1413 Baltimore, MD 21203 D<u>orota Marshall</u> 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury Exam Hospital or Attending Physician; The law requires that the death certificate be executed use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) signed by the attending physician defacted for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month Day Year 2 No Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Yes After this certificate has been 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed death? 2 DHO Yes Yes 2 filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 🗌 Yes မ ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 1 Depatient 2 🗌 . Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending 1 🗌 Yes Investigation Accident hin 24 hours after deatl the Funeral Directors Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the best of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29d. Date signed (Month, Day, Year) 29b. Signat 3a) (Type, Print) 30. Name and address of person who completed cause of

DHMH 17 Rev 06-2011

State Registrar Date filed (Month, Day,

32. Registrar's Signa

Edward William Ne	1	, III - For State	Sta	te of Maryla		artment of tificate of		and Ment	tal Hy		eg. No.	14	0940
Physician Medical Examine	1	Registrar 1. Decedent's Name Edwa	(First, Middle, ard W	. Nest,	III				1	2. Date of Dea Month March 20,	th Day Year		Time of Death 0155 hrs
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ural", or	oy rune	11. Marital Status 1 Never Marrie 3 Widowed 15. Decedent's Ed	4 Divor	ried Armed F 1 Yes ced If Yes, Give Yes or Dates:	2 No		es, specify Cu	ban, Mexican, No specify:	Puerto F		14. Race - White, Specify:	etc. Wh	n Indian, Black, Lite ustry
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Baltimore, permit. Pages 1 a Department of He Important: If its injury or other to		1 Burial 2 4 Donation 5	Cremation Other Spe	3 🔀 Removal fi	rom State GC	crematory or other	oherd C	emeter		27/2012	Andover	Gre	en Townshi
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Division of Vital Records, P.O. tal or Attending Physician: The law requires that the rest after death. La Divector: After this certificate has been signed by led in by the fineral director, page 2 should be deach different at the property of the fineral director, page 2 should be deach different at the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of	Completed									1 Yes	osy pr rmed? de		osy findings available apletion of cause of
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Divisic	Certification	2 ✓ Accident 3 Suicide 4 Homicide	Investi 6 Could determ	not be 28e. Plac	ce of Injury - At h		et, factory, offi	ce building, etc	c. 2	28f. Location (Street and Number		Route Number, City
8 - 8 >	Medical	29a. Certifier (Check only		rsician: To the be	of examination a								ause(s)
P. P. P. D. D. D. D. D. D. D. D. D. D. D. D. D.	Me	29b. Signature and	title of certifier	and manner s	sidleu.		_	ense number	*	aline quir manafini al re	29d. Date signe March 20, 2		, Day, Year)
101	-	30. Name and address	1///		ise of death (Item		W. Baltimo	ore Street,	Baltim	ore, MD 21	223		
Star Registra	-	31. Date filed (Mont	h, Day, Year) 2 7 20	82. R	egistrar's Signati	are back	,			-		<u>Ol</u>	nant.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2012 March 22, Physician/ Marcia Elizabeth Nelson 10:05 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's Royal Care Assisted Living Ft. Washington 8. Date of Birth (Month, Day, Ye Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs **Funeral** Months **Director** 023-14-7781 89 1 M 2 XF May 15, 1922 Yrs. Massachusetts Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location must be notified at Director 1 Yes 2 X No MD Prince George's Ft. Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò Funeral items 23a 11818 Tregiovo Place USA 20744 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian Was Decedon Armed Forces? ¹ ☐ Yes 2 X No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. ifiled within 72 hours after data Hygiene. o 9 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates Specify: White Completed 3 Divorced 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Book Store Manager traumatic event. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ marked Alfred Walter Nelson Hazel Dell Roberts and lis m 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) . Page 1 and 2 sl tment of Health a tant: If item 27 is Patricia M. Pastuszak/neice 215 Madaket Road Nantucket, MA 02554 other 20b. Place of Disposition (Name of cemetery, crematory or other p 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any injury or o Final Journey Crematory 03/27/12 1 Durial 2 Decremation 3 Removal from State Woodbine, MD 4 Donation 5 Other (Specify) 21. Sign July of Funeral Se Going Home Cremation Service P.O. Box 784 HOUSE MO1251 Boverly L. Heckrotte, P.A. Clarksville MD 21020
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition Failure to Thrive Medical resulting in death) Due to (or as a consequence of Examiner Breast Cancer Sequentially list conditions Examiner Due to jor as a consequence of cause. Enter Underlying Dementia Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Year Day 1 Yes 2 No g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ Division of Vital Records, 1 Tes 2 X No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed' 1 Yes 2 No Yes 2X No Be 25. Was case referred to medical 26. Place of Death (Check only one) assisted Hospital: Other: 2 X No 1 Tes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 X Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury 1 X Natural 5 Pending Investigation after death Director: / Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated United Territying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one

State Registrar

, _ _

MAR 2 7 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

29b. Signature and title of certifier

Kanwaljit Nagi,

31. Date filed (Month, Day, Year)

256063

1500 Forest Glen Rd. Silver Spring, MD 20910

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Nalle James marci 20 Medical Facility Name (if not institution, **Examiner** give street and number or Location of Death 4c. County of Death Balt JOHNS HOPKINS OSPI more 8. Date of Birth (Month, Day, **Funeral** Year If Under 24 Hrs Birthplace (State or Foreign Country) 402-43-5414 Hours **Director** 1 ▼M 2 □ F 20 11/14/1991 Kentucky 10b. County 10c. City, Town or Location with the Maryland 10d. Inside City Limits Directo or 28a-f s notified Kentucky Bullitt Louisville 1 Yes 2X No 10e. Street and Number 10f. Zip Code ö 10g. Citizen of What Country? pe Completed by Funeral 23a U.S.A. items 23a ier must t 40229 271 Spring Lake Court permit. Page 1 and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 14. Race - American Indian, Hygiene. other than "natural", or ite ent, the Medical Examiner Black, White, etc. 1 XNever Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2 🔀 No Specify White Specify: 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Loader Shipping Company other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic eve 2 James Nalley Melissa Tippin 9a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
271 Spring Lake Court Louisville, Kentucky 40229 Melissa Nalley 20b. Place of Disposition (Name of cemetery, crematory or other place)
Borden Cremation Ser. 03/26/2012 20a. Method of Disposition 20c. Location - City or Town, State 1 🔲 Burial 2 💢 Cremation 3 🗆 Removal from State Louisville, Kentucky 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Marzullo Funeral Chapel, P.A. 6009 Harford Road Baltimore, Maryland 21214 Nioruill 23a. Part 1. Enter the disease, or a mplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line Immediate Cause (Final Vascul Onset and Death Physician/ Nervous disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Physician/Medical Exam Cause (Disease or injury that initiated events resulting in death) Last attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Year 5 Other (specify) been signed by the s should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 ☐ Probably 4 ☐ Unknown Completed 1 Tes page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 autopsy performed 2 No Yes 2 🗆 1 🗌 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one Be Other: 2 No ျှ 1 Yes 1 Anpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death e Hospital or Attending P 24 hours after death. e Funeral Director: After t Date of injury 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 X Natural 5 Pending (Month, Day, Year) 2 Accident
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4 Homicide 1 Yes 2 No Investigation M 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗌 Certifying Nurse Prectitioner: To the best of my knowledge, deeth consured at the time, date and place, and due to the cause(e) and manner as stated within 2 29b. Signature and title of certifier 2 29c. License number £5-000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 600 North Wolfe St. Battimore, Wan-Tsu Chana 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 27 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Physician/ 3:30 PM Henry Joseph Nowowiejski 2012 March Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore County 233 Patapsco Avenue Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1 🙀 M 2 🗆 F Months Director 82 215-24-7344 31,1929 Maryland Usual Residence of Decedent show or 28a-f shov notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director MD N/ABaltimore City 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò . Page 1 and 2 should be filed within 72 hours after death with the irnent of Health and Mental Hygiene.

tant: If item 27 is marked other than "natural", or items 23a or jury or other traumatic event, the Medical Examiner must be Is Funeral 6702 Graceland Avenue 21224 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces' Black, White, etc b 1 Never Married 2x Married 2 No 1 X X es If Yes, Give 21215-0036 1 ☐ Yes 2X No Specify: White Specify: 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) American Can Co. Mechanic 12 Years Be 18. Mother's Name (First, Middle, Maiden Surname) Baltimore, Maryland 17. Father's Name (First, Middle, Last) ဂ္ Josephine Makalklewicz Joseph Nowowiejski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21224 Baltimore, Maryland Lorraine V. Nowowiejski(Wife) 6702 Graceland Ave. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Page 1 a
Department of H
Important: If ite
any injury or oth 1 🗷 Burial 2 🗆 Cremation 3 🗆 Removal from State Øt. 3/19/2012 5 Other (Specify) Stanislaus Cem. Baltimore, Maryland ature un rai Service Licenses 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. Dundalk, Maryland 21222 Wise Ave. ert . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each ling Interval Between Onset and Death Immediate Cause (Final Stage colon Cances Phyllician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ___ in the past 12 months? Month Dav Year Pregnant at time of death 2 No g Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Onknown 24a, Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 1 Yes 2 Wo Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 \(\text{Nursing Home} \) 1 Nursing Home 5 \(\text{Residence} \) 1 Residence 6 \(\text{Other} \) Other (Specify) ည 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending 1 🗌 Yes 2 🗆 No ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation. Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D 69540. 21234 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 204 4413 words Walham

DHMH 17 Rev 7/2009

State

Registrar

filed (Month, Day, Year)

27 2012

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32. Registrar's Signature

12-02366

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Pamela Obringer		For State	ate of Mary	rland / [tment of <i>ficate of</i>		and I	Mental	I Hygie		, No. 2	01	2 0946	
Physician	<i>I</i> 1	Decedent's Name (First, Midd					_	· ·		2. D	ate of Death lonth arch 23, 2	Day \	Year	3. Time of Death 0733 hrs	
Medical Examine		Pamela Obring a. Facility Name (if not institution		number)			4b. City, To	wn, or Loc	ation of D		aicii 25, 2	4c. Coun	ty of Death)	
		4313 Joshua Court		1		Lister days	Street If Under	1 Voor	If Under 2	MUre Q	Date of Righ	Harfor		thplace (State or	
Funeral Director	5	. Social Security Number 213-72-5021	6. Sex		50	t birthday) Yrs	Months			Min.	01/05/		Foreig	^{untry)} Maryland	
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or items 23a or 28a-f sh	ו פני	1. Marital Status 1 Never Married 2 X		ecedent Ever in U.S. Forces? 13. Was Decedent of Hispanic Origin? (Sperifices) If Yes, specify Cuban, Mexican, Puerto F									hite, etc.		
s after d			vorced If Yes, Give or Dates:	Year		1 16a. Deceder	Yes 2			d of work	dono	Specia 16b. Kind of	,	hite	
15. Decedent's Education (Specify only highest grade of Elementary/Secondary (0-12) College (1-4 of Elementary/Secondary (0-12)						16a, Deceder during m	nost of work	ng life. Do	O NOT use	e retired)					
						Lawn S	ervic					Famil		iness	
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MD at 2 shc alith and alith and 27 is aumat		Gerard Obringe	er / Hust	oand _	Tanh Di	4313 ace of Dispo				Stre	et, Ma	rylan	d 211 on - City or	.54 Town, State	
Baltimore, permit. Pages 1 ar Department of Hee Important: If ite injury or other tr		1 Burial 2 X Crematic	n 3 Remova	al from State	, cr	ematory or of	ther place)			13/2/	/2012	Ralti	more	Maryland	
it. Pagartment ortant		4 Donation 5 Other S 21. Signature of Funeral Service	Specify: e Licensee All v	rson K	Tay	lor 22.	Name and	ddress of	Facility (Crema	tion S	Societ	y of	Maryland	
Depu Depu	1	aldriku				29	99 Fre	deri	ck Ro	oad,	Baltin	nore,	Maryl	and 21228 Approximate Interval	
Physician	1	23a. Part DEnter the disease, of failure. List only one cause	e on each line.				the mode of	ayıng, su	cn as card	glac or res	piratory arre	st, shock, or	neart	Between Onset and Death	
Examiner		Immediate Cause (Final diseas or condition resulting in death)		Gunsnot as a conseq										1	
•		Sequentially list conditions,	b	as a conseq	uence of):										
		if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	C					_							
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68760 certificate b nding physise as the bu		IF FEMALE: 3b. Was decedent pregnant in		es, outcome ve birth	of pregna		etal death	3	Ectopic p	oregnancy		23d. Date Mont	e of deliver h	ry Day Year	
Box 6876(e death certificate the attending phy ced for use as the b	Physician/M	past 12 months? 1 Yes 2 No 9 ✔ U	4 P	egnant at ti	me of dea	=	ther (Spec	ify)				1000			
cords, P.O. Box 6876(law requires that the death certificate has been signed by the attending phy 2 should be detached for use as the be	Š.	Part II. Other significant cond		nknown ng to death l	but not res	sulting in the	underlying	cause give	en in Part	l.	23e. Did to	bacco use c	ontribute to	the cause of death?	
P.C res that signed to be deta	함									_		2 🗸 No			
Cords	Completed							_			24a. Was a autops perfor	sy		utopsy findings available completion of cause of	
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Vital Recysician: The his certificate director, page	å	25. Was case referred to medic examiner?	Hospital:	Inpatien	2 1	ER/Outpatier		-		Check only Nursing H	one)	Residence	6 🗸 Othe	er: Scene	
of Vi	위	1 Yes 2 No 27. Manner of Death	28a. [ate of Injury	, 	28b. Time of		8c. Injury	at Work?	280	Describe h	now injury oc			
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Divisipital or At ours after deeral Direct filled in by	Certification:	de	uld not be			me, farm, str ily Home	еет, тастогу,	onice bui	iding, etc.		or Town, S 3 Joshua (tate)		aran rode rumber, exy	
		29a. Certifier 1 Certifying	Physician: To the	best of my	knowledg	e, death occ	urred at the	time, date	and place	e, and due	e to the caus	e(s) and ma	nner as sta	ated.	
To the Hos within 24 h To the Fur completely	Medical			asis of exam ner stated.	ination an	nd/or investig		. License		urred at the	e time, date :			onth, Day, Year)	
	2	29b. Signature and title of certi					250	O.C.M					24, 2012		
		30. Name and address of pers	on who completed	cause of de	ath (Item	23a)						L			
(g√			tant Medical E	xaminer				t, Baltin	nore, M	ID 2122	3				
Sta Registi		31. Date filed (Month, Day, Yea		2. Registral		1. 400	aked			_					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 22 Day 2012 ar March James Ohle Harry 10:50 P-M Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death <u>Senator Bob Hooper Hospice House</u> Forest Hill Harford 8. Date of Birth (Month, Day, Y Oct. 15, **Funeral** 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Days **Director** 1943 Washington, D.C. 1 🙀 M 2 🗆 F 213_40_1216 Usual Residence of Decedent 68 Yrs. bct. 28a-f show Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Start If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 😾 No Maryland _Harford Forest Hill 10e Street and Number 10g. Citizen of What Country? Funeral 10 Lockhart Circle Apt. B. 21050 United States 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, other traumatic event, the Medical Examiner Black, White, etc. ģ 1 Never Married 2 X Married Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify: Completed 3 Divorced 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Jewelry Jeweler 11 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Leo Baldwin Alice Ohle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Victoria Ohle / Wife 10 Lockhart Cricle Apt. B. Forest Hill, MD 21050 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Mar. Date 26, 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot Evans Funeral Chapel 1 Burial 2 X Cremation 3 Removal from State 4 Donatio 5 Other (Specify) 2012 Forest Hill, Maryland Bel Air 21. Signature 22. Name and Address of Facility Evans Funeral Chapel & Cremation Service—BelAir 3 Newport Drive Forest Hill, Maryland 21050 23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one ns that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) ancer Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be execute Due to (or as a consequence of): Physician/Medical Hacky ALE Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Pregnant at time of death Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 1 Tyes 2 🗌 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 No Other: မ 1 Inpatient 2 Inpatient 3 Inpatient 2 Inpatient 3 Inpatient 2 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 2 Inpatient 3 Inpatient 2 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpa 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural 5 Pending injury ☐ Accident☐ Suicide М 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2

To the F

complete 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2300 DUANEY VALLEY RD TIMONIUM, MD 21093 State Registrar

2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Antonio Knapp Olmedo MARCH 23, 2012 2:10A Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death BALTIMORE SAINT JOSEPH MEDICAL CENTER ${ t TOWSON}$ 5. Social Security Number If Under 1 Year Months Days 8. Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign Country 022-32-1271 **Director** 1 **XX**M 2 ... F 81 September 24,1930 Philippines Usual Residence of Decedent 28a-f shov 10a. State 10c. City, Town or Location 10d. Inside City Limits other traumatic event, the Medical Examiner must be notified at Director Maryland Baltimore Towson 1 🗆 Yes 2 🗓 No 20 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 707 Hickory Lot Rd. 21286 United States 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 XNo Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 XX No Specify: If Yes, Give 3 Nidowed 4 Divorced Specify: white Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 5+ physician medical Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Jose Maximo Olmedo Adelina Knapp ge 1 and 2 should be at of Health and Mer If item 27 is marke 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joseph M. Olmedo/son 707 Hickory Lot Rd. Towson, MD 21286 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other p Date 20c. Location - City or Town, State perfuit. Page 1
Det artment of
Important: If i
any injury or c 1 XXBurial 2 Cremation 3 Removal from State ☐ Donation 5 ☐ Other (Specify) Dulaney Valley Mem GardMar. 27,2012 Timonium, Maryland John O. Mitchell Ty, Funeral Services of Dulaney Valley 21. Signature of Funeral Service Licensee 200 E. Padonia Rdí Timonium, MD 21093 23a. Pat 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, speck, or heart failure. List only one cause on each line.

Imm diate Cause (Final I.TVFR FATTLIBE Onset and Death
YEARS LIVER FAILURE Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) 5 YEARS Examiner MYELODYSPLASIA Seductially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of): by Physician/Medical Box 68760 yes, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No Month Day Vear P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed' 2 XN To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?

1 Yes 2 No Other: 1X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 🛚 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical Exertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0059711 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LINDA ADLER, MD. 7601 OSLER DRIVE TOWSON, MD 21204 31. Date filed (Month, Day, Year)
MAR 2 7 2012 32. Registrar's Signature **State**

Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 7:15 A M 25 March Opfer Claire Rose Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Harford Jarrettsville 4112 Croftleigh Court Birthplace (State or Foreign Country)
 MD 8. Date of Birth (Month, Day, Yea If Under 1 Year If Under 24 Hrs Social Security Number Age (In yrs. last birthday, 6. Sex Funeral Min 1 🗆 M 2 🗶 F Months Hours Director 212-62-6417 56 July 11 1955 Usual Residence of Decedent fled within 72 hours are...tal Hygiene.ed other than "natural", or items 23a or 28a-f show ed other than "natural", or items 23a or 28a-f show mant, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State Directo 1 Yes 2 XNo Jarrettsville Harford County MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Numbe Funeral USA 21084 4112 Croftleigh Ct. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: white 3 Widowed 4 X Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) traumatic event, the Floral Sales & Floral Arranging Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) of Health and Mental File of Health and Mental Fitem 27 is marked or မ Rose Claire Banister Joseph Allen Garliss 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13921 Sunnybrook Rd., Phoenix, MD 21131 Richard Opfer/ex-husband/POA/PR 20a Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1
Department of
Important: If it
any injury or o ☐ Burial 2 👿 Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) 3/29/12 Glen Burnie, MD Atlantic Crematory ^{22. Name and Address of Facility} Lemmon Funeral Home of Dulaney Valley Inc. 10 W. Padonia Road, Timonium, MD 21093 Clary Bryan W. 23a. Part 1. En er the lisease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, heart f-liure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate ause (Fi al Breast Physician/ disease or condition resulting in death Medical 13840 Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): sician and burial-transit Exami Cause (Disease or liniury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician I for use as the buria Physician/Medical certificate be Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No To the Hospital or Attending Physician: The law requires that the death ate has been signed by the atte page 2 should be detached for Month Day Year Pregnant at time of death 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed Yes 2 X death? within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page 2 🗌 No ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 2 1 ☐ Yes 2 💢 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury work?
1 Yes 2 No (Month, Day, Year) 1 X Natural 5 Pending Investigation Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆 only one) 29d. Date signed (Month, Day, Year) 29b. Signature March 26, 2012

State Registrar

DHMH 17 Rev 7/2009

North Charles St. Suite 201, Towson, MD 21204

ss of person who completed cause of death (Item 23a) (Type, Print)

6569

MD

Celano,

Pau1

31. Date filed (Month, Day, Year), MAR 27

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year 8:00 ам **Physician** Donald Douglas Patterson 20,2012 March /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Futurecare Canton Harbor 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) North Carolina If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1**⊠** M 2□ F 58 Nov. 23, 1953 220-64-0514 Director Usual Residence of Decedent 10d. Inside City Limits within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10a. State if item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examinations to pulling at 1 Yes 2 □ No Baltimore Maryland Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21224 IISA 306 S.Conkling Street Funeral 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Black, White, etc. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Black Specify ģ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Value Village s 1 and 2 should be filed within if Health and Mental Hygiene. Item 27 is marked other than ' College (1-4or 5+) Elementary/Secondary (0-12) Warehouseman <u>11th grade</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ruby Lee Wiggins John Charles Patterson Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 306 S.Conkling St.Baltimore, MD. 21224 Blanche Patterson/Wife 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition permit. Pages 1 Department of H Important: If ite any Injury or ot Baltimore, Maryland 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Mt.Carmel Cemetery 03-24-12 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Chatman-Harris Funeral Home 4210 Belair Rd.Baltimore, Md. 21206 Signature of Funeral Service License Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** resulting in death) /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Exam and as the burial-trai Due to (or as a consequence of): sate has been signed by the attending physician page 2 should be detached for use as the buria Box 68760 Hospital or Attending Physiclan: The law requires that the death certificate be Physician/Medical IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month Year 5 ☐ Other (specify) ☐Yes 2 ☐Mo P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Division of Vital Records, ò 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 2 1No 2 certificate 1 ☐Yes 26. Place of Death (Check only one) the funeral director. 25. Was case referred to medical examiner? Be Other: 4☐ Hursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 ☑ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Certification: To 27. Manner of Death

1 Watural
2 Accident 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 24 hours after death. Funeral Director: After (Month, Day, Year) Injury 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide filled in by determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely within 2 29d. Date signed (Month, Day, Year) 29b. Signature at 30. Name and address of pe

DHMH 17 Rev 1/2001

State Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) Month Physician/ 2012 9:29 A. Brenda Ann Popp March Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Gilchrist Hospice Center @ GBMC Baltimore Towson 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number **Funeral** Director 213-66-9410 1 M 2 XF 57 Feb. 9, 1955 Maryland Usual Residence of Decedent or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits must be notified at with the Maryland Director 1 Yes 2 XNo Maryland Harford Edgewood 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 818 Cloverleaf Court 21040 USA Page 1 and 2 should be filed within 72 hours after death vent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Was Decedent Ever in U.S 11. Marital Status event, the Medical Examiner Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 Yes 2 X No If Yes, Give Specify: White Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Billing Clerk Healthcare Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Patricia Ann Bellamy Cecil Edward Wiland 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 818 Cloverleaf Court, Edgewood, Maryland 21040 Vernon James Popp / Husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Page 1
Department of
Important: If it
any injury or c 1 🔲 Burial 2 🔀 Cremation 3 🗆 Removal from State 3-28-2012 Bel Air, Maryland Rose Hill Svcs, LLC 4 Donation 5 Other (Specify) 22. Name and Address of Facility McComas Funeral Home, P.A. Signature of Funeral Service I censes 1317 Cokesbury Road, Abingdon, Maryland 21009 Farl 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) sequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) To the Hospital or Attending Physician; The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been sioned by the attending abusing and as the burial-trai that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 1 ☐ Live Birth 2 ☐ Fetal Gea 4 ☐ Pregnant at time of death 9 ☐ Unknown Month Dav Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown filled in by the funeral director, page 2 should 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy performe 1 Yes 2 No 1 Yes 2 N 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be မ 1 Tes 4 Nursing Home 5 Residence 1 Inpatient 2 I ER/Outpatient 3 I DOA 28c. Injury at work? 1
Yes 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: injury 1 X Natural 5 Pending Investigation Accident 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature 29d. Date signed (Month, Day, Year, 18215000 3/23/12 Rune and address of person who completed cause of death (Item 23a) (Type, Print)
Philip Shaheer, 6701 N. Charles St. # 4105 Balthrere, MD 21204 State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death March Physician/ 2012 A. Pinson 07:00 A M Anna Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Tate Hospice House Anne Arundel Linthicum If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Months Davs (Month, Day, Year, 220-20-3235 Director 1 🗆 M 2 🔀 F 83 July 18 1928 MD Yrs Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10c. City, Town or Location with the Maryland Director notified Odenton Anne Arundel 1 Yes 2 X No Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or ms 23a or must be Funeral USA 21113 1212 Odenton Road items permit. Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian. Armed Force If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. , or by 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: White "natural" Completed 3 Widowed 4 Divorced Medical Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry c than " Elementary/Secondary (0-12) College (1-4 or 5+) Tailoring Seamstress ulth and Mental Hygier 27 is marked other t r traumatic event, th Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 Zalsaneslsis Horant Nellie John Ρ. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other tratonce. 3205 Hernwood Road, Woodstock, MD 21163 Linda Feaga (daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date March 1 Durial 2 XCremation 3 Removal from State Baltimore, Maryland Metro Crematory Inc. 4 ☐ Donation 5 ☐ Other (Specify) 2012 Signature of Funeral Service Licenses 22. Name and Address of Facility Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 21122 23a. Part 1. Enter the disease, or complications that caused the deal shock, or heart failure. List only one cause on each line. n. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ 1-8 disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): Cause (Disease or injury that initiated events the Hospital or Attending Physician: The law requires that the death certificate be executed physician and is the burial-trans Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 attending IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Fctopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ 1 ☐ Yes 2 ☒No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an page 2 s autopsy perform certificate Yes 25. Was case referred to medical director, 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 4 \square Nursing Home 5 \square Residence 6 \triangleright Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work?
1 \(\sum \) Yes 28d. Describe how injury occurred After Natural injury 5 Pending within 24 hours after deau.

To the Funeral Director: After the funeral py the funeral py the funeral py the funeral py the funeral py the funeral py the funeral py the funeral py the funeral py the funeral py the funeral py the funeral py the funeral py the funeral py the funeral py the funeral py the funeral py the funeral py the funeral py the funeral py the funeral py the funeral py the funeral py the funeral py the funeral py the funeral py the funeral py the funeral py the funeral py the funeral py the funeral py the funeral py the funeral py the funeral py the funeral py the funeral py the funeral py the funeral py the funeral py the funeral py the funeral py the funeral py the funeral py the funeral py the funeral py the funeral py the funeral py the funeral py the funeral py the funeral py the funeral py the funeral py the funeral py the funeral py the funeral py the funeral py the funeral py the funeral py the funeral py the funeral py the funeral py the funeral py the funeral py the funeral py the funeral py the funeral py the funeral py the funeral py the funeral py the funeral py the funeral py the funeral py the funeral py the funeral py the funeral py the funeral py the funeral py the funeral py the funeral py the funeral py the funeral py the funeral py the funeral py the funeral py the funeral py the funeral py the funeral py the funeral py the funeral py the funeral py the funeral py the funeral py the funeral py the funeral py the funeral py the funeral py the funeral py the funeral py the funeral py the funeral py the funeral py the funeral py the funeral py the funeral py the funeral py the funeral py the funeral py the funeral py the funeral py the funeral py the funeral py the funeral py the funeral py the funeral py the funeral py the funeral py the funeral py the funeral py the funeral py the funeral py the funeral py the funeral py the funeral py the funeral py the funeral py the funeral py the funeral py the funeral py the funeral py the funeral py the funeral py the funeral py the fu 2 🗌 No 2 Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Registrar

only one)

29b. Signature and title of certifier

R 2 7 2012

person who completed car

32. Registrar's S

anature

29d. Date signed (Month, Day, Year)

Φ

State Registrar 32. Registrar's Signature

Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

30. Name and address of person who completed cause of death (Item 23a)

Theodore M. King, Jr., MD.

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death March 17, 2012 Physician/ PM7:55 Jacob Pokras Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Prince George's Adelphi Hillhaven Nursing Home 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Numbe 7. Age (In yrs. last birthday, **Funeral** 96 **Director** 108-09-0109 1 🛛 M 2 🗆 F March 19, 1915 Connecticut ms 23a or 28a-f show must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State Director 1 Yes 2X No Silver Spring Maryland Montgomery 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 20901 United States 9509 Saginaw Street 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No WWII, If Yes, Give Korea, Year or Dates: Vietnam Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: White 3 X Widowed 4 Divorced Completed Il Hygiene.
I other than "natura vent, the Medical E 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) U.S. Army Lieutenant Colonel 4 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Rose Freidland Benjamin Pokras 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9509 Saginaw Street, Silver Spring, Maryland 20901 Robert Pokras/Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of F
Important: If ite
any injury or ot Marchate 24, 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) 2012 Bethesda, Maryland Montgomery Crematorium 21. Signature of Funeral Service License 22 Name and Address of Facility Robert A. Pumphrey Funeral Home, Bethesda—Chevy Chase, Inc. Milhan M01173 7557 Wisconsin Avenue, Bethesda, Maryland 20814 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death
5 minutes Immediate Cause (Final disease or condition Cardiac Arrythmia Medical resulting in death) Due to (or as a consequence of): **Examiner** 25 years Coronary Heart Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. • Funeral Director: After this certificate has been signed by the attending physician and Hypertension 25 years that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical 40 years Hyperlipidemia Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) Pregnant at time of death Yes 2 No 9 Unknown signed by i Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Obstructive Uropathy 1 Yes 2 X No 3 Probably 4 Unknown 24b. Were autopsy findings available Benign Prostate Hyperplasia 24a. Was an prior to completion of cause of death? autopsy Anemia, Arthritis 1 Yes 2 No 1 Yes 2 X No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 1 Inpatient 2 ER/Outpatient 3 DOA မ 4 X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) filled in by the funeral Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 5 Pending 1 X Natural 1 🗌 Yes 2 🗌 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hosp within 24 hou To the Funer completely fi 29a. Certifier X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 [Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie Net D17843 March 20, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

Vivek C. Vaid, M.D.

31. Date filed (Month, Day, Year)

32. Registrar's Signature

3311 Toledo Terrace #B-102, Hyattsville, Maryland

DHMH 17 Rev 1/2001

12-02328	
Stephen Roe	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		I- For State Registrar	ate of maryland	•	tificate of		ia mema		leg. No. 20	2	0941
Physicia Medical Examin	n/	1. Decedent's Name (First, Midd Stephen Lenn:						2. Date of Dea Month March 6,	Day Year		3. Time of Death 1050 hrs
	ı	4a. Facility Name (if not institution 586 Welbrook Road	on, give street and number		4	b. City, Town, o	or Location of D		4c. County of		nty
Funeral Director		5. Social Security Number 220–17–6767	6. Sex 7. Ag	e (In yrs. Ia	st birthday) Yrs.	If Under 1 Ye	_	Min. 8. Date of Bi	rth(MM/DD/YYYY) /1971	Foreign	
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eath with the Maryland items 23a ur 28a-f shuw	Q L	10e. Street and Number 586 Welbrook		ES	Sex	10f. Zip Code 2122	1		10g. Citizen of Wha	at Count	21
r death with t	- L	11. Marital Status 1 Never Married 2 M	arried 12. Was Decedent Armed Forces 1 Yes 2		If Ye	Decedent of H	lispanic Origin? an, Mexican, Pu	(Specify Yes or No erto Rican, etc.)	o- 14. Race - White,	etc.	an Indian, Black,
\$ £ \$	<u>a</u>	3 Widowed 4 Div 15. Decedent's Education (Spe Elementary/Secondary (0-12)		<u> </u>	16a. Decedent				Specify:		
21215-0036 July be filed within 7 Mental Hygiene. marked uther than c event, the Medica	91	10 17. Father's Name (First, Middle Forrest Roe,			Paint	er		ame (First, Middle,		prov	rement
d be fenta	To Be	19a Informant's Name/Relations Forrest Roe,	hip (Type, Print)		19b. Mailing 421	Address (Stre	et and Number	eline Tro or Rural Route Nur l Baltimo:	mber, City or Town	, State, i Land	Zip Code) 21224
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours a Department of Health and Mental Hygiene. Important: If item 27 is marked ather than "natural injury or other traumatic event, the Medical Examin		20a. Method of Disposition 1 Burial 2 Cremation 4 Donation 5 Other S		ate cr	lace of Disposit rematory or other dent Cr	er place)		Date 03/23/12	20c. Location - 6	•	
Balti permit. Departi Importi		21. Signature of Funeral Service	ricensee	,	60	09 Hari	ord Koa	larzullo d Baltimo	ore, Mary	/Lan	d 21214
Physician /Medical Examiner		23a. Part I. Enter the disease, or failure. List only one cause Immediate Cause (Final disease or condition resulting in death)	on each line.	eroti	c Cardi				est, shock, or hear	t	Approximate Interval Between Onset and Death
		Sequentially list conditions, if any, leading to immediate	b. Due to (or as a const							\dashv	
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Box 68760, re death certificate be the attending physici ned for use as the buri		IF FEMALE: 3b. Was decedent pregnant in the past 12 months?	4 Pregnant at		2 Eeta	el death 3	Ectopic pre	gnancy	23d. Date of d Month	lelivery Da	ay Year
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ords law requ has been 2 should	ompleted by	Obesity;Chron	ic Obstructi	ve S1	еер Арі	nea		24a. Was	an 24b. W	ere auto	opsy findings available impletion of cause of
Vital Rec	ا د	25. Was case referred to medica				26.Plac	e of Death (Che	1 ✓ Yes		✓ Yes	2 No
F Vita	9	examiner? 1 ✓ Yes 2 No 27, Manner of Death	Hospital: 1 Inpatie		ER/Outpatient 28b. Time of Inj		Other Nu		Residence 6		Scene
ion of trending Ph leath.	cation:	1 X Natural 5 Pend	(Month, Day,Y	ear)	ess. Time of my		Yes 2 No	Zod. Describe	now injury occurred		
Divis pital or At our after d teral Direct filled in by	Certific	3 Suicide 6 Coul	d not be rmined (Specify)	jury - At hon	me, farm, street	, factory, office	building, etc.	28f. Location (or Town, S		or Rura	al Route Number, City
To the Hos within 24 hd To the Fun completely	edical	one) 2 Medicai Exa	hysiclan: To the best of m miner:On the basis of exam and manner stated.			on, in my opinio	n, death occurre		and place, and du	e to the	cause(s)
		29b. Signature and title of certifie	a-Pole	٠	~		.M.E.		29d. Date signed March 22, 2	·	h, Day, Year)
ϕ		30. Name and address of person Patricia Aronica-Polla				00 W. Balti	more Street	, Baltimore, M	D 21223		
Sta Registra		31. Date filed (Month, Day, Year) MAR 2 7 2012	Ochem 32. Registra	's Signature	w						

DHMH 17 Rev 1/2001 OCME 2006

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day Agnes Mary Riesett 2012[°] 23. 9:48 P M March Medical **Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Local Parkville County of Death
Baltimore ocation of Death 3103 Edgewood Avenue Social Security Number . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year, **Jrne** 22, 1925 219-10-0668 Days Hours **Director** 1 M 2 X F 86 Baltimore, Maryland Usual Residence of Decedent or 28a-f show notified at 10b. County 10c. City. Town or Location Director 10d. Inside City Limits MD Baltimore Parkville 1 Yes 2 No 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? nan "natural", or items 23a o Medical Examiner must be Completed by Funeral 3103 Edgewood Avenue 21234 United States 11. Marital Status Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 XNo
If Yes, Give Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Specify: White 3 X Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Hygiene. other than ' Elementary/Secondary (0-12) B&O Railroad College (1-4 or 5+) Clerk nd Mental Hygier marked other t 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) f and 2 should be fi Health and Mental Item 27 is marked ည Frank Charles Simon Anne M. Gibreyer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael Riesett- Son 3022 Putty Hill Avenue Parkville, Maryland 21234 Department of Healt Important: If item 2 any injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) March Date 27, 20c. Location - City or Town, State Page 1 1 XBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Baltimore, Maryland Woodlawn Cemetery 2012 Signature of Funeral Service Licenses 22. Name and Address of Eacility Evans Funeral Chapel & Cremetion Services 8800 Harford Road Parkville, Maryland 21234 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Ph_, sician/ Onset and Death disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of Exami that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Box 68760 IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 month 1 Yes 2 No Month Day Year Pregnant at time of death 1 Yes 2 9 Unknow P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? 2 X No e Hospital or Attending Physician: 1 124 hours after death. e Funeral Director: After this certifice 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 \square Nursing Home 5 X Residence 6 \square Other (Specify, မ 1 Tes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA completely filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28c. Injury at 28b. Time of 28d. Describe how injury occurred 5 Pending 1 X Natural work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical **Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 12/022 3-27-12 cray 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7602 BOYAINING MOO. MS ZIZ36 Kon State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Robert James Rhinehart March 24, Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Gilchrist Center Columbia Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, **Funeral** Days Hours Min Director 111-42-8523 1 🛛 M 2 🗆 F 57 April 08, 1954 28a-f show ral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director Baltimore Nottingham MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 121 Sipple Avenue 21236 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 【XNo If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) þ 1 Never Married 2 Married 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: "natural" Completed 3 Widowed 4X Divorced Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) other than Elementary/Secondary (0-12) Bravo Health College (1-4 or 5+) 12 Accountant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Robert William Rhinehart Patricia Madeline Appel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Eric Potter- Partner 121 Sipple Avenue, Nottingham, Maryland 21236 20a. Method of Disposition 20b. Place of Disposition (Name of March 27, 20c. Location - City or Town, State 1 Burial 2 XCremation 3 Removal from State 4 Donation 5 Other (Specify) Evans Funeral Chapel Forest Hill, Maryland 2012 Pel Air 22. Name and Address of Facility Ewans Funeral Chapel & Cremation Services 8800 Harford Road Parkville, Maryland 21234 Signature of Funeral Service Licensee t 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac ock, or heart failure. List only one cause on each line. iate Cause (Final Physician/ OWNO TODA se or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examir Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical death certificate be Box 68760 IE FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Pregnant at time of death 1 Yes 2 L 9 Unknown 9 Unknown P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Records, To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has be Be 25. Was case referred to medica Division of Vital 26. Place of Death (Check 2 No Hospital Other: 1 Yes ုင 1 Inpatient 2 ER/Outpatient 3 00A Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate:

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itions, ediate ng ury	b	Due to (or as a consequ	uence of):					
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egnant nths? No		if yes, outcome of pregna 	al death 3 🗌 Ectop	oic pregnancy (specify)			23d. Date of de Month	livery Day Year
ant conditions of	ontrib	uting to death but not res	sulting in the underlying	ng cause given in Part I.				the cause of death?
						24a. Was an autopsy performed? 1 Yes 2	prior to	topsy findings available completion of cause of
to medical				26. Place of Death (Che	eck on	ly one)		
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5 Pending Investigation	,	28a. Date of injury (Month, Day, Year)	28b. Time of injury M	28c. Injury at work? 1 Yes 2 No		. Describe how inju		
Could not b determined	e 2	8e. Place of Injury - At he building, etc. (Specify		tory, office	28f	. Location (Street a City or Town, Stat		ral Route Number,
Medical Exami	ner:	On the basis of examination	n and/or investigation,	d at the time, date and place, in my opinion, death occurred occurred at the time, date and p	at the	time, date and place	e, and due to the	cause(s) and manner stated.
e of certifier	ı	wer Cln	10	29c. License number		29d. D	ate signed (Monti	n, Day, Year)
of person who	ompl	eted cause of death (Item	n 23a) (Type, Print)					
Sutula	6	336 Corb	r Lane	Columnia	W	D 210<	14	
012 /2	CASA.	32. Registrar's Signa	iture					

2012 Year

4c. County of Death

Howard

United States

Specify:

14. Race - American Indian. Black, White, etc.

White

11:42 Р м

Birthplace (State or Foreign Country)

10d. Inside City Limits

1 Yes 2 No

New York

State Registrar

npletely filled in by the

Medical

5 Pending

Name and address of person who completed cause of death (Item 23a) (Type, Print)

6 Could not be

Accident

☐ Suicide

4 Homicide

29b. Signature and title of certifie

29a. Certifier

DHMH 17 Rev 06-2011

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For State	State of M	laryland / Depa	irtment of H tificate of D			2001	0 001.78
Registrar 1. Decedent's Name (First, Middle,	Last)	Cer	tificate of L	jeatri	2. Date of Dear	Reg. No 🛴 🔱 🖟	3. Time of Death
Physician/ Medical	Marcelline	M. Ruhl			Month March	22, 2012	
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Gildrist Hos 5. Social Security Number		ge (In yrs. last birthday)	If Under 1 Year	WSCN If Under 24 Hrs.	8. Date of Birth	Balti	Birthplace (State or Foreign
Funeral 5. Social Security Number 220–34–7497	1 □ M 2 XX F	75 Yrs.	Months Days	Hours Min.	(Month, Day, April 18	Year) (Country)
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10a. State 10b. County Maryland Balt 10a. State 10b. County 10b. County 10c. Street and Number	imore	10c. Oity, Town or Loc	Phoeni:	x			1 Yes 2XX No
a b a lo a lo a lo a lo a lo a lo a lo a			10f. Zip Code			10g. Citizen of What	Country?
14430 Jametts 1 1. Marital Status				1131			s of America
G 1 ☐ Never Married 2 XXMarri	12. Was Decedent Armed Forces? 1 \(\text{Yes} \) Yes	<u> </u>	Vas Decedent of Hi Yes, specify Cuba	spanic Origin? (Spe n, Mexican, Puerto	Rican, etc.)	14. Race - Ar Black, Wi	nerican Indian, nite, etc.
3 Widowed 4 Divorced	If Yes, Give Year or Dates.	1	☐ Yes 2 XXNo	Specify:		Specify:	White
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20a. Method of Disposition		20b. Place of Dispo	sition (Name of		Date	20c. Location - City	
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IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	e of pregnancy 2 Fetal death 3	Ectopic pregnanc	°V		23d. Date of	delivery
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Division of Vital Records, all or Attending Physician. The law requires a Briter cleath. I Director. After this certificate has been signed in by the funeral director, page 2 should be completed. Certificate: To Manuel of Death To Manuel of Death To Manuel of Death To Manuel of Death To Manuel of Death To Manuel of Death To Manuel of Death To Manuel of Death To Manuel of Death To Manuel of Death To Manuel of Death To Manuel of Death To Manuel of Death To Manuel of Death To Manuel of Death To Manuel of Death To Manuel of Death To Manuel of Death To Manuel of Death To Manuel of Death To Manuel of Death To Manuel of Death To Manuel of Death To Manuel of Death To Manuel of Death To Manuel of Death To Manuel of Death To Manuel of Death To Manuel of Death To Manuel of Death To Manuel of Death To Manuel of Death To Manuel of Death To Manuel of Death To Manuel of Death To Manuel of Death To Manuel of Death To Manuel of Death To Manuel of Death To Manuel of Death To Manuel of Death To Manuel of Death To Manuel of Death To Manuel of Death To Manuel of Death To Manuel of Death To Manuel of Death To Manuel of Death To Manuel of Death To Manuel of Death To Manuel of Death To Manuel of Death To Manuel of Death To Manuel of Death To Manuel of Death To Manuel of Death To Manuel of Death To Manuel of Death To Manuel of Death To Manuel of Death To Manuel of Death To Manuel of Death To Manuel of Death To Manuel of Death To Manuel of Death To Manuel of Death To Manuel of Death To Manuel of Death To Manuel of Death To Manuel of Death To Manuel of Death To Manuel of Death To Manuel of Death To Manuel of Death To Manuel of Death To Manuel of Death To Manuel of Death To Manuel of Death To Manuel of Death To Manuel of Death To Manuel of Death To Manuel of Death To Manuel of Death To Manuel of Death To Manuel of Death To Manuel of Death To Manuel of Death To Manuel of Death To Manuel of Death To Manuel of Death To Manuel of Death To Manuel of		njury - At home, farm, str rtc. <i>(Specify)</i>	eet, factory, office	Į	City or Tow	n, State)	Hurai Houte Number,
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29b. Signature and title of certifier	W 5		29c. License	_		29d. Date signed (Mo	
9	m.n			11287		3-23-17	<u></u>
30. Name and address of person w	een,670(N. Cheele	St. *4	105, Be	altime	re, MD	21204
State 31. Date filed (Month, Day, Year) Registrar MAR 2 7 2012	Second 32. Regist	trar's Sinature					,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ 2012 March つず 4:25 A M Riley Marie Medical 4a. Facility Name (if not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Towson Gilchrist Hospice 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In vrs. last birthday **Funeral** Months Hours Director 1 🗆 M 2 🔀 F 217-76-0395 Maryland 08/23/1957 54 28a-f show 10d. Inside City Limits 10h County 10c. City, Town or Location item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at **Funeral Director** 1 X Yes 2 No Harford Joppa MD 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Numbe U.S.A. 21085 1043 Plaza Circle filed within 72 hours after death 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 X Married þ Yes 2 X No Yes, Give Maryland 21215-0036 1 Yes 2 X No Specify: 3 Widowed 4 Divorced White Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16h Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) Medical Medical Transcriptionist Page 1 and 2 should be filed with ment of Health and Mental Hygien ant: If item 27 is marked other? Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 Schmidt Rose Loretta Wienholt Lawrence Ε. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1043 Plaza Circle, Joppa, MD 21085 Douglas S. Riley / Husband Department of Health Important: If item 2; any injury or other tonce. Baltimore, 2Cb. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 03/26/2012 | Hanover, Maryland 4 X Donation 5 Other (Specify) Anatamy Gifts Registry 22. Name and Address of Facility Anatomy Gifts Registry 21. Signature of Juneral Service Liopnsee 7522 Connelley Dr, Ste. P, Hanover, MD 21076 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final OF DIABETEL Fnysician/ DICATIONS YEAV25 disease or condition Medical resulting in death) Examiner Sequentially list conditions Examine Dusity (or es a consectionne of): cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Completed by Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy 23d, Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Live Birth 2 Fetal death Ectopic pregnancy in the past 12 months? Month Day Pregnant at time of death 9 Unknow g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? the funeral director, page 2 should be 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy performed? 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: ျ 1 Tes 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify, Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Certificate: work? 1 ☐ Yes 2 ☐ No injury 1 Natural 5 Pending Investigation Accident 24 hours after deat Funeral Director: 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined filled in Medical ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated completely (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar only one)

29b. Signature and title of certifier

LON HARVES 31. Date filed (Month, Day, Year, MAR 2

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

within 24

29c. License number

2012

N Charles ST TONSON MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 0543 Robinson Hudrey March 2012 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner University of Maryland Medical Baltimore Center If Under 1 Year If Under 24 Hrs.
Months Davs Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Director 214-38-7244 1 □ M 2 🛛 F Maryland 07/20/1939 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10b. County Director 1 XYes 2 No Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 1 and 2 should be filed within 72 hours after death with 1 if Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a U.S.A. 874 W. Fairmount Avenue 21201 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 X Widowed 4 Divorced Black Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Medical Nutritional Assistant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Gwaltney Marie Horace Lee 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 8319 Lacewood Lane, Pikesville, MD 21208 Kenneth Jones / Son injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition □ Burial 2 □ Cremation 3 □ Removal from State Anatomy Gifts Registry 03/22/2012 Hanover, Maryland 4 ☑ Donation 5 ☐ Other (Specify) 21. Signature of Saneral Service Licensee 22. Name and Address of Facility Anatomy Gifts Registry 7522 Connelley Dr., Ste. P, Hanover, MD 21076 or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final disease or condition Preumonia Physician/ resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or injury that initiated events ed by the attending physician and detached for use as the burial-trar Due to (or as a consequence of) resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE yes, outcome of pregnancy

Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Pregnant at time of death g 🗆 Unknown sate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 X Unknown 24b. Were autopsy findings available 24a, Was an autopsy performed? Yes 2 No prior to completion of cause of certificate has 1 Yes 2 No 1 Yes filled in by the funeral director, 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ 1

Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 24 hours after deatl Funeral Director: 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier within 24 hor To the Fune completely f (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie M.D 1841589926 20 March 2012

State Registrar

DHMH 17 Rev 06-2011

Baltimore, Maryland

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Street

32. Registrar's Sig

Greene

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Betty Mauck Ritter 2012 7:20 March Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b, City, Town, or Location of Death 4c. County of Death 3809 Forest Drive Chesapeake Beach Calvert Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Virginia Hours Months onth, Day, Year) 09/28/1942 1 □ M 2 🔀 F Director 228-64-3568 69 Yrs. Usual Residence of Decedent show 10a. State 10b. County at 10c. City, Town or Location 10d. Inside City Limits Director notified 28a-f 1X Yes 2 ☐ No MD Calvert Chesapeake Beach 10e. Street and Number 10f. Zip Code ms 23a or must be n ö 10g. Citizen of What Country? Funeral 3809 Forest Drive ural", or items ! 13. Was Decedent of Hispanic Origin? (Specify Yes or Nolf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 X Married þ Page 1 and 2 should be filed within 72 hours afterment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify Specify. Completed 3 Widowed 4 Divorced White the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Administrator Architecture of Health and Mental Hygie If item 27 is marked other ir other traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Leonard Mauck Annie James McSpadden 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James W. Ritter / Husband 3809 Forest Drive, Chesapeake Beach, MD 20732 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State ō 1 Burial 2 X Cremation 3 Removal from State Department of Important: If any injury or once, 4 ☐ Donation 5 ☐ Other (Specify) 3/25/2012 Chesapeake Crematory Beltsville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Dorota Marshatt Maryland Cremation Services, PO Box 1413 Baltimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final LIVER Onset and Death Physician/ CIRRHUSIS disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Cause (Disease or injury the attending physician and hed for use as the burlal-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death 1 Yes 2 Unknown detached by to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed' Yes 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 🕒 No 1 Tyes ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at Certificate: 28b. Time of 28d. Describe how injury occurred Director: After 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident Investigation filled in by the 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital 24 hours Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hor To the Fune completely fi 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) N. Mendons 200 60638 3194112

Registrar

DHMH 17 Rev 06-2011

State

310

PRINCE

MD 20678

PREDERICAL

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ROAD

32. Registrarts Signature

#

HOSPITAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2:45 a.m M Ratcliff Virginia Christine March 22, 2ŎĨ2 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death
Baltimore 4b. City, Town, or Location of Death Examiner Timonium Stella Maris Hospice Social Security Number Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** Age (In yrs. last birthday) Days Hours Min Director 214-26-6066 1 M 2 X F 82 November 29, 1929 |South Carolina Usual Residence of Decedent 28a-f show 10b. County 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location Director N/A Baltimore 1 X Yes 2 No Maryland 10g. Citizen of What Country? USA 10e. Street and Number 10f. Zip Code 21206 Funeral 5915 Meadow Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married Yes 2 X No Maryland 21215-0036 Specify: White 1 ☐ Yes 2 🙀 No Specify. 3 ¥ Widowed 4 □ Divorced Completed Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Textile Textile Worker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name *(First, Middle, Maiden Surname)* Lillian Sullivan 2012 ၉ James Otis Hardy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5915 Meadow Road Baltimore MD 21206 Michele Ratcliff/Daughter Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Gardens of Faith 1 XBurial 2 Cremation 3 Removal from State Baltimore MD 3/26/12 4 ☐ Donation 5 ☐ Other (Specify) . Signatur Fun ral Service Licensee 22. Name and Address of Facility Leonard J. Ruck, Inc. 5305 Harford Road Baltimore MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ CONGESTIVE HEART FAILURE Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of): burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last CHRISTINE RATCLIFF attending physician Completed by Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Month Year Pregnant at time of death 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 Yes 2 No 1 🗌 Yes 2 🙀 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Tother (Specify) HOSPICE 2 **X** No ER/Outpatient 3 DOA မ 1 Yes 1 Inpatient 2 I After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred injury X Natural 5 Pending 1 Yes 2 No Accident Investigation 24 hours after deat Funeral Director: Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 🗶 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the l 29b. Signature and title of certifier 29d. Date signed (Manth, Day, Year) 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2300 DULANEY VALLEY RD. TRACIE L. MORGAN, CRNP TIMONIUM, MD 21093 31. Date filed (Month, Day, Year)

DHMH 17 Rev 06-2011

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2012 Physician/ March 21, Riley 1:37 a Linda K. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Gilchrist Hospice Center Towson If Under 1 Year If Under 24 Hrs.
Months Davs Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) . Age (In yrs. last birthday, **Funeral** Months Days 218-48-0693 Director 1 □ M 2🗶 F 64 Yrs Maryland September 24,1947 Usual Residence of Decedent or 28a-f show 10d. Inside City Limits 10a, State 10c. City, Town or Location Director Medical Examiner must be notified at Dundalk Md. Baltimore 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 7403 Manchester Road 21222 USA Page 1 and 2 should be filed within 72 hours after death vert of Health and Mental Hyglene.

ant. If item 27 is marked other than "natural", or items ury or other traumatic event, the Medical Examiner mu Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Specify: White If Ves Give 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Medical Assistant Doctors Office 12 years Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Robert Elbert Margaret Long 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7403 Manchester Road, Dundalk, Md. 21222 Robert J. Rilev Husband 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of March 24, 1 🔀 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) cemetery, crematory or other place) Department of Important: If any injury or Dundalk, Maryland Oak Lawn Cemetery 2012 22. Name and Address of Facility
Connelly Funeral Home of Dundalk, P.A.
7110 Sollers Point Road, Dundalk, Md. Signature of Fungral Service Licensee Mithon Part 1. Enter the disease, co complications that caused the death on not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Medical SCUAMOS cell concenona months disease or condition resulting in death) **Examiner** Sequentially list conditions, Due to the as a consequence of Examine cause. Enter Underlying Cause (Disease or injury and burial-tra that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Completed by Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 use as the IF FEMALE yes, outcome of pregnancy
Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death Yes 2 No 1 ☐ Yes 2 ₽ 9 ☐ Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? untastate rend cell 2 No 3 Probably 4 Unknown Carcinoma director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an ankin discove has autopsy perform 2 🗌 No certificate Yes 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: ၉ 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify No Specify this filled in by the funeral 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: 28c. Injury at After injury 1 Natural 5 Pending 1 Tyes 2 🗌 No 24 hours after death. Funeral Director: A Investigation Accident 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Homicide Medical 14 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one Within 2 29c. License number 29b. Signature and title of certifier 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6701 N. Chances ST wo (0 V WALLES 31. Date filed (Month, Day, State 7

DHMH 17 Rev 06-201

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2012 Year Bette Gail Sheeler March 12:16 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Dove House Hospice Carroll Westminster Social Security Number If Under 1 Year If Under 24 Hrs. 8 Date of Birth Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** Months Min Hours 214-46-8152
Usual Residence of Decedent **Director** 1 M 2 XF 65 Aug 30. 1946 Maryland show 10a State 10b. County at 10c. City, Town or Location 10d. Inside City Limits Director notified 28a-f 1 Yes 2 XNo Glen Rock Penna York 10e. Street and Number 10g. Citizen of What Country? ms 23a or must be r Funeral 4732 Glenville Road 17327 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ō þ 1 Never Married 2X Married Ves Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: White Specify: "natural" Completed 3 Widowed 4 Divorced Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) the Homemaker 12 Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) th and Mental F 27 is marked or traumatic even ည Beulah Steffev Hobert Woolen Flanagan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health George A. Sheeler, Husband <u>4732 Glenville Road Glen Rock, Penna 17327</u> 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 \square Burial 2 X Cremation 3 \square Removal from State ō Department of Important: If any injury or Metro Crematory Inc. 03/23/12 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland Signature of Funeral Service Licenses Thomas Gregor ChameandAddress Scilly Of Maryland, Inc. 299 Frederick Road Baltimore, Maryl Maryland 21228 23a. Part 1. Enter the disease, of complications shock, or heart failure. List only one cause Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): -trar and that initiated events resulting in death) Last Due to (or as a consequence of): burial physician Physician/Medical P.O. Box 68760 as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ___ in the past 12 months?

1 Yes 2 No Dav Pregnant at time of death 1 Yes 2 2 g Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of death? 2 No Yes 2 [1 Tyes Be 25. Was case referred to medical examiner? Division of Vital 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 ☐ No Other: 1 Inpatient 2 ER/Outpatient 3 DOA ၉ 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accider iniury work? 1 🔲 Yes 2 🗌 No 5 Pending Investigation Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 \square Homicide determined City or Town, State) Hospital Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 29b. Signature a 29d. Date staned (Month, Day, Year) 30. Name and addre Westminster

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month,

Day, Year,

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Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. The strict of the 27 is marked other than "natural", or items 23a or 28s-f show or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 Burial 2 XCremation	n 3[Removal from	ء اینہ	rematory or o	other place)		1			•
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - trans		29a. Certifier 1 Certifying	Physic kamine	r:On the basis of	f examination a	ge, death occurred ind/or investig	curred at the tim	ne, date and inion, death	place, and o	due to the cause the time, date a	e(s) and manner a and place, and due	s stated. e to the cause(s)
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	-	Musto:					0	C.M.E.			March 24, 20	012

30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 Ana Rubio MD. State 31. Date filed (Month, Day, Year)
Registrar MAR 9.7 201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of Mar	yland /		tment of F ficate of L			ental Hy	giene Reg. No.	201	2	09486
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	Funeral	Г	5. Social Security Number 6. Sex	7. Age (l)	n yrs. last b		f Under 1 Year lonths Days	If Unde Hours	er 24 Hrs. 8 Min.	B. Date of Bir	th ly, Year)	9. Bi		e (State or Foreign
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	s after death with the Maryland ral", or items 23a or 28a-f shc Examiner must be notified at		11. Marital Status	12. Was Decedent Ever Armed Forces? 1 Yes 2 No	r in U.S.	13. Was	Decedent of H		rigin? (Specif an, Puerto Ric	y Yes or No- can, etc.)		14. Race - Am Black, Whi		Indian,
21215-0036	within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at	ed by	1 X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ⚠ No If Yes, Give Year or Dates.			Yes 2X No						hit	e
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687	pertification programme as as	n/Me	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of p	pregnancy			-				2d Data of da	di com c	
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	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director. After this certificate is completely filled in by the funeral director, pag	Medical	29a. Certifier (Check conly one) 1 Certifying Physic 2 Medical Examine only one) 3 Certifying Nurse	er: On the basis of exam	ination and	or investigat	ion, in my opinio	n, death c	occurred at the	e time, date a	nd place a	and due to the	cause(s	s) and manner stated. d.
_	vith To t		29b. Signature and title of certifier				29c. License	number			29d. Date	signed (Monti	h, Day,	Year)
			30. Name and address of person who con	mpleted cause of death	(Item 23a)	(Type Print	1000	536	94		3	-26	- 2	012
12) <i>V</i>		DR Daniel L. Sh	inners	900	OFA	Ankli	u S	Quas.	e DR	Ba	Hom	d	21237
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MARCH 24, 2012 10:24 a.m. LOUGENIA STINSON

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-	Physicia Medi	cal		STINSON						Month 03 -		0/2	10:24A	Л
	Examir	ner	4a. Facility Name (if not institution, give STEULA MARIS 5. Social Security Number 6. Se	HOSPICE	last hirthday)		M	Mok	25	8. Date of Bi		Inty of Death	nplace (State or Foreig	
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3	Medical Examiner		disease or condition resulting in death)	a. END STAGE Due to (or as a consec		DISEASI	<u> </u>					_		_
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	Q		30. Name and address of person who c				<u></u>			~ 1	<u> </u>			
	Sta Registra		TRACIE L. MORGAI 31. Date filed (Month, Day, Year) MAD O 7 2012	32. Registrar's Signa		Y_VALL	EY]	KD.	TIMO	ONTUM,	MD_210	93		_
	riegisti	all.	MAR 2 7 2012 A	rece of the	tikal									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 | | 2 09488 Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) 3. Time of Death Month Year Physician/ Juanita Sue Sager 5:01 P 2012 March Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Gilchrist Center Towson Baltimore Birthplace (State or Foreign Country) Social Security Number 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** Months Hours Director 218-36-9722 69 1 M 2 X F September 7,1942 Shady Springs, W or 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits the Maryland Director notified 1 Yes 2 X No Maryland Baltimore Nottingham 10f. Zip Code 10g. Citizen of What Country? pe Funeral 23a 4300 Cardwell Avenue Apt. 223 21236 United States Examiner must "natural", or items within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black, White, etc. 1 Never Married 2 Married by 1 ☐ Yes 2 X No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Specify: White 3 Widowed 4 Divorced Completed h and Mental Hygiene.

27 is marked other than "natural" Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home Be Page 1 and 2 should be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Alunzo Capps Eva A. Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a Florence Kaleo (Sister) 1302 Demby Road Towson, Maryland 21286 Department of Heal Important: If item 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) March 25, 2012 Evans Funeral Chapel-Bel Forest Hill, Maryland 22. Name and Addres Facility Sin Liture of Funeral Service Licensee, Evans Funeral Chapel & Cremation Services-Parkville 8800 Harford Road Parkville, Maryland 21234 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Imme late Cause (Final Physician/ MOTASTATIC rue to (or as a consequence of): MONTH disea e or condition resting in death) Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-tra Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No
9 Unknown 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Month Dav Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by OMBOUSN ULMONARY 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No Yes 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA . Manner Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? Natural 5 Pending 2 No Investigation Accident 2 Accident
3 Suicide
4 Homicide within 24 hours after deatl To the Funeral Director: . completely filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifie address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 06-2011

State

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death . Decedent's Name (First, Middle, Last) Month Year **Physician** 03 19 2012 1:10 A Fern Cooper Schultheis /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Long View Nursing Home Manchester Carroll Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🛛 F Months Days Hours 215-22-0130 MD 85 Director 08/17/1926 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County 28a-f show Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Invoical Examinar must be notified at XXYes 2 □ No Director MD Carroll Manchester 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number 21102 USA Funeral 3332 Main St 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2X No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify White þ 3X Widowed 4 □ Divorced Year or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) 12 accounting moving company 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 should be fi Be ပ Louis F. Jefferson, Sr. Hazel Wolfenden 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1 and 2 s /f Health s Louis Harding/son 1860 Hoff Lane, Finksburg, MD 21048 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Pages 1 ō Important: If it any Injury or o 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Loudon Park 03/23/2012 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Prints Funeral Home and Chapel, P.A. ignature of Funeral Service Licensee 412 Washington Road, Westminster, MD 21157 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 10 **Physician** ar KINSONS YEARS disease or condition /Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Exami and burial-trar Due to (or as a consequence of): Box 68760, signed by the attending physician be detached for use as the buria certificate be Physician/Medical IF FEMALE yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. ☐Yes 2No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown cate has been signal page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 □ Yes 2 No 1 ☐Yes 2 ☐No or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: Hospital: 2 XNo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes Certification: To this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred After 1 (Month, Day, Year) 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only

State Registrar

29b. Signatore and title of certifier

29c. License number

POOLE Road

29d. Date signed (Month, Day, Year)

WISTM, OSTEr

01

and manner stated

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mantha L. Schulz 03/24/2012 1207PM Baltimore, Maryland 21215-0036 $\mu_{\rm ALOC} + 2 \ell \nu_{\rm Box} = 0.000$ Division of Vital Records, P.O. Box 68760

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		State Registrar 1. Decedent's Name	e (First, Midd)	e. Last)				Ce	rtificat	te of E	Death		2. Date of D	Reg. N	4o.4 U	16	3, Time of) J U
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Funeral Director		5. Social Security No. 243-90-00	lumber	6. Sex	M 2 🔀 F		(In yrs. la	ast birthday) Yrs.		er 1 Year		er 24 Hrs.	8. Date of E (Month, L	Day, Year,	- 1	Cour	**	Foreign
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P		30. Name and addr	ress of person	who co	mpleted cau		eath (Item	1 23a) (Type,	Print)			ervil	le Md		093			
Sta Registr		31. Date filed (Mon	th Day Year)	_	32.	Registra	r's Signa		P.			, ,	1					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 2 Date of Death 22 Day Physician/ March 2012^{cal} Duane Alfred Schauer 5:47 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Mandrin House Anne Arundel Harwood Social Security Numbe 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Year If Under 24 Hrs. g, Birthplace (State or Foreign **Funeral** Months Davs Hours 501-32-4778 1 X M 2 🗆 F Director 05/30/1935 North Dakota 76 10d. Inside City Limits 10a, State 10c. City, Town or Location Director r 28a-f sl notified Prince George's MD Bowie 1 Yes 2 No 0 10e Street and Number 10f Zin Code 10g. Citizen of What Country? ms 23a or must be n Funeral 3800 Irongate Lane 20715 "natural", or items edical Examiner mu within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 K Yes 2 □ No 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married ģ 1 ☐ Yes 2 ☐ No Specify Baltimore, Maryland 21215-0036 Specify: 3 Widowed 4 Divorced Completed Year or Dates Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) th and Mental Hygiene.
27 is marked other than 'r
traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) Field Engineer IBM Computers 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname Alfred Schauer Ida Kessler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27 is permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once. Carol Johnson Schauer/spouse 3800 Irongate Lane, Bowie, MD 20715 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Maryland Veterans Cemi. 3/27/2012 Crownsville, Maryland onation 5 C Other (Specify) ignature of Fundral Service Libease 22. Name and Address of Facility Beall Funeral Home 6512 NW Crain Hwy., Bowie, MD 20715 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Chronic obstructive lung disease Physician/ End stage Medical resulting in death) Due to (or as a cos sequence of) Examiner Sequentially list conditions, Examine Due to for as a consequence of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last and Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 the IE FEMALE: 23c, If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death Unknown 9 Unknown To the Hospital or Attending Physician: The law requires that the within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detach. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?
1 Yes 2 No 1 ☐ Yes 2 🗹 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 1 ☐ Yes 2 ☑ No မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? 1 ☐ Yes 2 ☐ No 5 Pending Accident
Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Rate Feel M.D. D4 344 6 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Anapolis Road Suit 200 Glandle MD

Registrar

31. Date filed (Month, Day, Year) 32. Registrar's Signature

12150

ROINTAN FARAHIFAR

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		•	For State Registrar	State of	waryian	•	artment of H tificate of D		d Mental Hy	giene Reg. No. 2	012	09492
	Physicia	m/	1. Decedent's Name (First, Middle,	Last)					2. Date of De	eath	V	3. Time of Death
	Medic		Henry Fi	rederick	Smi	th			March	22, 2	2012	5:04 P ^M
	Examin	er	4a. Facility Name (if not institution,		r)		4b. City, Town, or	Location of D	eath		ty of Death	
agent.	Funeval		Gilchrist Cer 5. Social Security Number		Age (In yrs. la	set hirthday)	Towso	If Under 24	Hrs. 8. Date of Bi		timor	e place (State or Foreign
	Funeral Director		197-05-7592	1 🔀 M 2 □ F	nge (m yrs. ra	Yrs.	Months Days		Min. (Month, Da		Coun	try)
	wo		Usual Residence of Decedent	71	96				May 9,	1915		sylvania
	yland f sho	ctor	10a. State 10b. County		10c. City	, Town or Lo	cation				1	0d. Inside City Limits
	e Ma r 28a notifi	Sire	Maryland Balt: 10e. Street and Number	lmore		Ti	monium					1 Yes 2 X No
	ith th	rall		1 D 1 #2/	. 7		10f. Zip Code	2		10g. Citizen o		itry?
	be filed within 72 hours after death with the Maryland ental Hygiene. ked other than "natural", or items 23a or 28a-f sho ic event, the Medical Examiner must be notified at	Funeral Director	12240 Roundwood	12. Was Deceder	nt Ever in U.S	. 13. V	2109 Vas Decedent of His	spanic Origin?	(Specify Yes or No	US	A ace - Americ	an Indian.
တ္	ter de , or it imine	ρ	1 Never Married 2 Marri		s? □ No	"	Yes, specify Cubar	n, Mexican, Pu	uerto Rican, etc.)	ВІ	ack, White,	
8	ursaf tural" al Exa	Completed	3 X Widowed 4 □ Divorced	If Yes, Give Year or Dates	i.		Yes 2 X No	Specify:		Speci	fy: Wł	nite
5	72 ho "nat	nple	15. Decedent (Specify only highes			(Give I	ent's Usual Occupa and of work done do	ition uring most of	working	16b. Kind of	Business/Ind	dustry
12	ithin iene. r thai	S	Elementary/Secondary (0-12)	College (1-4 o	or 5+)		o NOT use retired) Accountan	+		Δ11#	omobi	1 6
Ď	iled wall Hyg othe	Be	17. Father's Name (First, Middle, La			•			Name (First, Middle	-		10
Maryland 21215-0036	should be filed within 72 hours after death with the Maryland nand Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Examiner must be notified at	욘	Henry	Frederic	ζ	Smi	th		Viola	Τe	es	
lan.	shoul and I is ma auma		19a. Informant's Name/Relationshi	p (Type, Print)		19b. Mailin	g Address (Street a	nd Number o	Rural Route Numb	er, City or Town,	State, Zip C	Code)
رٌ	und 2 Healith Im 27 her tr		Karen Smith/Dau	ighter				od Roa	d, #307,			
Baltimore,	ge 1 and tof H		20a. Method of Disposition 1 ☐ Burial 2 🏋 Cremation		ate C6	emetery, cren	sition (Name of natory or other place		Date	20c, Location	•	
₫	iit. Pa		4 Denation 5 Other (Sc	\sim 2	Atl		Cremator		/24/12	Glen B	urnie	, Maryland
Ba	permit. Page 1 and 2 should be fi Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev		21 June Juneral Style Li	(Mully		22	Name and Address Lemmon Fu 10 W. Pad	neral onia R	Home of Doad, Timo	ulaney nium. M	Valle D 210	y Inc.
			23a. Part 1. Enter he disease, or on shock, or leart failure. List or	complications hat comply one cause on each	sed the death line.						201	Approximate Interval Between
-	Tiysician,	0	Immediate Cruse (final disease or condition	-1 100	らしし	tan					- 1.	Onset and Death
	Medical Examiner		resulting in de	D e to (or	as a consequ	ence of						
		ner	Sequentially list conditions, if any, leading to immediate	b. Due to (or	as a consequ	ence of):						
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)U	G) =	<u> </u>	resulting in death) Last	Due to (or a	as a consequ	ence of):						
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189	certifica inding p use as	Me	IF FEMALE:	23c. If yes, outcor	ne of pregnar	ncv						
Rox	atten atten	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No		h 2 🗌 Fetal	death 3	Ectopic pregnancy Other (specify)	1			ate of delive Ionth	Pry Day Y ear
о. Б	requires that the death been signed by the atte should be detached for	hysi	9 Unknown	9 ☐ Unknow								
л О	that the	by P	Part II. Other significant condition	1		_			23e. Did 1	obacco use cor	ntribute to th	e cause of death?
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Ř	The I	5	peripheral vous	ular du	Last					ormed?	death?	2 🗆 No
Vital	ician: sertific ector,	m	25. Vas cas referred to medical examiner?	Hospital:			26. Pla		Check only one)			
₹	Phys this ral dir	임	1 Yes No 27. Manner of Death	1 ☐ Inp	atient 2 🔲 l	ER/Outpatien 28b. Time of	t 3 DOA Other	4 L Nursir	g Home 5 Resi			nospile
Division of	nding th. : After e fune	Certificate:	1 Natural 5 Pending	(Month,	Day, Year)	înjury	work?			how injùry occu	rrea	
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2	tal or irs aft al Dir led in			1 12	etc. (Specify)				City or To			
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical	(Check 2 Medical Ex	Physician: To the best aminer: On the basis of	of examination	and/or invest	gation, in my opinior	n, death occun	red at the time, date	and place, and d	lue to the cau	se(s) and manner stated.
	o the	Σ	only one) 3 L Certifying I 29b. Signature and title of certifier	Nurse Practitioner: To	the best of m	y knowledge,	death occurred at th		nd place, and due to	the cause(s) and 29d. Date sign		
	- S - O) (Dara	Mr.	>		DE	9302	_	Marie	4 27	2012
	EX,		30. Name and address of person w	ho completed cause of	f death (Item	23a) (Type, P	rint)		2	, , , ,	0	
	1.0		AARON SCHA	PUES MI	670	N 10	- Chr	les 5	TOW	50N/	no	
	Stat Registra	-	31. Date filed (Month, Đay, Year)	2012	trar's Signati	ire Z	Med					
1	Registra		MAR 27	LUIL Come	m f	1. 140	~~					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Physician/ LOVENCE Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Examiner Clifton Bultimore Avenue If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth 7. Age (In yrs. last birthday) 6. Sex Social Security Number **Funeral** Min (Month, Day, Year) 215.01.6937 1 🗆 M 2 💢 F MI **Director** 16. 101 10d. Inside City Limits 28a-f show 10c. City, Town or Location 10b. County 10a. State er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director 1 Yes 2 No Balti move MD 10g. Citizen of What Country? 10e, Street and Number by Funeral 11. S.A. 21216 HUENUE Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?.
1 Yes 2 No If Yes, Give Year or Dates. 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Tes 2 No Specify. Specify: Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) filed within 72 tal Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Deam Stress traumatic event, Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) should be file and Mental H is marked or မှ 017 inwood 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Pnnt) Department of Health ar Important: If item 27 is any injury or other trau 20b. Place of Disposition (Name of Date 20a. Method of Disposition Burial 2 Cremation 3 Removal from State Mam. 4 Donation 5 Other (Specify) Signature of Funeral Service License Fral Home North ANERLE 23a. Part 1/ Enters he disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed the burial-tran resulting in death) Last Completed by Physician/Medical Box 68760 as IF FEMALE: use 23d. Date of delivery 23b. Was decedent pregnapt Year Month in the past 12 months 1 Yes 2 No Day 1 Yes 2 4 g Unknown Division of Vital Records, P.O. ģ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy filled in by the funeral director, page 2 performed 2 🗆 No Yes 2 N 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 2 1 No 4 Nursing Home 5 Residence 6 Other (Specify 1 Inpatient 2 ER/Outpatient 3 DOA ၀ 1 Yes 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death 28c. Injury at Certificate: work? 1 🗆 Yes 2 🗆 No Natural 5 Pending Investigation Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier only one) 29d. Pate signed (Month, Day, Year) 20c. License number 29b. Signature and ≰itle of 1200 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Serb AUDO 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAR 2 7 2012 Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ William Ray Stice March Ž012 10:05 AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death 7960 Clark Station Road Anne Arundel Severn 6. Sex 1 M 2 F 5. Social Security Number . Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Davs Hours Min (Mo09/12/1937 405-52-1670 Kentucky Director 74 Yrs Usual Residence of Decedent show "natural", or items 23a or 28a-f sho 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MD Anne Arundel Severn 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7960 Clark Station Road 21144 USA death \ Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian Armed Forces?
1 X Yes 2 Black, White, etc. Page 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene.

ant: If item 27 is marked other than "natural", or þ 1 Never Married 2 Married 2 Army Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Specify 3 Widowed 4 XDivorced Completed White Year or Dates item 27 is marked other than "natur other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Data Analyst Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Ray Marshall Stice Mary Elizabeth Lewis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard Terzigni / Brother In Law 7910 Crain Highway South, Glen Burnie, MD 21061 20a. Method of Disposition
1 ☐ Burial 2 🖸 Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1
Department of 1
Important: If it Chesapeake Crematory 3/25/2012 4 ☐ Donation 5 ☐ Other (Specify) Beltsville, MD Signature of Funeral Service Licensee 22. Name and Address of Facility Dorota Marshall Maryland Cremation Services, PO Box 1413Baltimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician disease or condition resulting in death) 0 mg Medical Due to (or as a consequence of Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Exami that initiated events resulting in death) Last Due to (or as a consequence of) burialphysician Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy for in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Dav Year Pregnant at time of death 9 Unknown Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ pe Division of Vital Records, 12 Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 certificate has performed? Yes 2 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 X No မ 1 Inpatient 2 ER/Outpatient 3 DOA After this 24 hours after death.
Funeral Director; After this etely filled in by the funeral of 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes Certificate: 28d. Describe how injury occurred injury Natural 5 Pending 2 🗆 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical Effectifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the only one) Signature and title of certifie completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 06-2011

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ March 2 Pay Judith Eloise Scott 2012 7:00 pm Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Berlin Nursing And Rehabilitation Berlin Worcester 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Days 1 □ M 2 🛛 F Months Min. Hours (Month/224/1940 ^CPemsylvania 159-32-4959 72 Director Yrs Usual Residence of Decedent 28a-f shor 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at Director 1 🗆 Yes 2 🔀 No MD Worcester Ocean City ò 10e. Street and Number 10f. Zip Code 10q. Citizen of What Country? Funeral 23a 12024 Ocean Gateway #8 21842 USA "natural", or items 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces Black, White, etc. 1 ☐ Yes 2 🕅 No If Yes, Give 1 Never Married 2 Married þ permit. Page 1 and 2 should be filed within 72 hours after. Department of Health and Mentia Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examin Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Widowed 4 XDivorced White Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Clerk Retail Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Albert D. Scott Mary E. Jester 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marybeth Brown / Daughter 12024 Ocean Gateway #8, Ocean City, MD 21842 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Chesapeake Crematory 3/23/2012 Beltsville, MD 21. Signature of Funeral Service 22. Name and Address of Facility Dorota Marshall Maryland Cremation Services, P O Box 1413Baltimore, MD 21203 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. 23a. Part 1. Enter the disease Interval Between Immediate Cause (Final Onset and Death Physician/ Icemia disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leaving to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or iinjury that initiated events sician and burial-trans Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical (F FFMALE yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy
 5 Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Day Pregnant at time of death 9 Unknown Unknown s been signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death?

1 Yes 2 No autopsy performe Yes 2 1 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 2 💢 No 1 Tyes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 2 Accider 3 Suicide injury 5 Pending 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Homicide

Hospital or Attending Physician: The law requires that the death certificate be Box 68760 Division of Vital Records, within 24 hours after deat

To the Funeral Director:
completed filled in by the 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated X Certifying, Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the Within 2 To the F only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) R 135131 March 22, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Pennie Savage, CRNP 9715 Healthway Dr. Berlin, MD 31. Date filed (Month, Day, Year) 32. Registrar's Si State Registrar DHMH 17 Rev 7/2009 **ORIGINAL**

闰

Judith

Scott,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Certificate of Death Registrar Decedent's Name (First, Middle, Last, 2. Date of Death 3. Time of Death Physician/ Day March 2012 3:15 PMPaul Woodruff Snyder Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Anne Arundel Medical Center Annapolis 5. Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. 9. Birthplace (State or Foreign If Under 1 Year 8 Date of Birth Country daho **Funeral** Days Min. Month Pay Year 20 517-05-8117 1 Å M 2 □ F 91 Director items 23a or 28a-f show ner must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland Director 1 X Yes 2 □ No Severna Park MD Anne Arundel 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 802 Pin Oak Road USA 21146 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11 Marital Status the Medical Examiner Armed Forces?

1 X Yes 2 NAir Force If Yes, Give Black, White, etc. ō þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify "natural", White Completed 3 XWidowed 4 Divorced Vear or Dates 15 Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Ith and Mental Hygiene. 27 is marked other than "I r traumatic event, the Med Elementary/Secondary (0-12) College (1-4 or 5+) Music Teacher Education 12 Be 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) 2 Margaret Templeton Jacks Roland Simon Snyder .. Page 1 and 2 should be tment of Health and Mer tant: If item 27 is marke 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 802 Pin Oak Road, Severna Park, MD 21146 Margaret Estelle Snyder-Gibson / Daughter Department of Health
Important: If item 2:
any Injury or other t 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Durial 2 X Cremation 3 Removal from State 3/25/2012 Beltsville, MD Chesapeake Crematory 4 Donation 5 Other (Specify) Signature of Funeral Service Licenses 22. Name and Address of Facility Maryland Cremation Services, PO Box 1413Baltimore, MD 21203 Dorota Marshall 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Ph_ician/ disease or condition Medical resulting in death) Due to or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Litter Underlying Cause (Disease or injury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed and the burial-trai that initiated events Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as 1 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ of Month Day Year Pregnant at time of death 9 Unknown 9 Unknown signed by a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available autopsy performed? page 2 2 1000 1 Yes certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 2 140 Inpatient 2 ER/Outpatient 3 DOA 1 🗌 Yes 4 Nursing Home 5 Residence 6 Other (Specify, 0 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Manner of Death Certificate: After Natural 5 Pending n 24 hours after death.

Re Funeral Director: At oletely filled in by the fu Investigation Accident 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a, Certifier Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2. 3 🗆 only one) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 001

DHMH 17 Rev 06-2011

State Registrar Date filed (Month, Day, Year)

32. Registrar's Signature

Division or Vital Records, P.O. Box 68760,

Examiner Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Physician/Medical signed by the at d be detached for þ Completed peen page 2 s this certificate or Attending Physician: director, Be Certification: To After thi funeral within 24 hours after death.

To the Funeral Director: / Hospitai

Physician

/Medical

Director

Funeral

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show r 28a-f show notified at

r than "natural", or items 23a or the Medical Examiner must be

permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a any injury or other traumatic event, the Medical

ysician

Medical

25. Was case referred to medical examiner? 1 ☐ Yes 27. Manner of Death Natural 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year) 32. Registrar's Signature

State Registrar

29b, Signature and title of certifier

the

SHETTLE, ANNA

			_ For	Please	Type or State of		Black II								gible.		
			State Registrar				Cei	rtificat	e of L	Death			Reg.	No.2 (112	0	9498
ı	Physicia	an/	Decedent's Name (First, Anna Luella		,							2. Date of D Month MARC		Day	Year .	3. Tin	me of Death
agin.	Medi Examir		4a. Facility Name (if not inst			ber)		4b. City,	Town, or	r Location of		MARCI	- 1		Year O 12 by of Death		59 P.M
17.00			FRANKLIN		_	Hosp	DITAL	#	305	EDA	E				LTII		E
	Funeral Director		5. Social Security Number 215–28–0702 Usual Residence of Dece		х Пм 2 х	7. Age (In yrs. 80	last birthday) Yrs.	If Under Months	1 Year Days	If Under 2 Hours	Min.	8. Date of B (Month, D August	Day, Yea		g. Birth Cour Mary]	ntry)	tate or Foreign
	/land f show	tor	10a. State 10b. C	County		10c. Ci	ity, Town or Lo								<u> </u>	10d. Insid	de City Limits
	ith with the Maryla ms 23a or 28a-f s must be notified	Direc	Maryland N 10e. Street and Number	/A			Balti										Yes 2 No
	with th	erall	5018 Frankford	Avenue				10f. Zip	206						What Cou	ntry?	
	items	Fune	11. Marital Status	nvende	12. Was Deced			Vas Deced	ent of H	ispanic Origi	n? (Spec	fy Yes or No	USA -	1	ce - Americ	an India	n,
21215-0036	1 and 2 should be filed within 72 hours after death with the Maryland Fhealth and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f shc other traumatic event, the Medical Examiner must be notified at	Completed by Funeral Director	1 Never Married 2 3 X Widowed 4 Div	vorced	1 Yes If Yes, Give Year or Dat	2 X No	- 1	Yes		n, Mexican, Specify:	Puerto R	can, etc.)			ck, White,		
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212	within rgiene. ser tha		Elementary/Secondary (i	0-12)	College (1-	4 or 5+)	Secre		-					Banki	ng		
Maryland	nould be filed with the marked other is marked other in matic event, the	To Be	17. Father's Name (First, Mi Edward C. Lamb	,								First, Middle	, Maide	en Suman	ne)		
ıryla	should b and Mer is mark aumatic		19a. Informant's Name/Rel				105 14-58	. 4.1.1	(0)		ian H						
	and 2 sh Health ar tem 27 is		Debra Neiss/Da		30, 7 11110					en Burn		Route Numb D. 210		or Town,	State, Zip (Code)	
Baltimore,			20a. Method of Disposition 1 D Burial 2 X Crem	nation 2 🗆	Domoval from 9	20b. F	Place of Dispo	sition (Nam	e of		Da		_	Location	- City or To	wn, State	e
tim	permit. Page Department o Important: If any injury or once.		4 Donation 5 O	ther (Specify)		Lltop Sei				/28/1	2	T	owson	MD		
Bal	permit. Par Departmer Important any injury		21. Signature of Funeral Se	rvioe License	00		122	Name and	Addres J. R	s of Facility	C.		m 0	101/			
			23a. Part 1. Enter the disea	ase, or comp	lications that ca	used the deat		O5 Har				nore, M espiratory a		1214		Approxi	imate
b	h, sician/		shock, or heart failure Immediate Cause (Final disease or condition	. List only on			NT F	FII	RAI	EF	File	inal				Interval	Between and Death
	Medical Examiner		resulting in death)		Due to (o	r as a consequ	NT F uence of): LUNG	, C C C.	(//		us	ION			-		
		Je.	Sequentially list conditions if any, leaving to immediate		STAC	E /V	LUNG	s CA	NCL	ER							
	executed an and rial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	1	NON.		EVATIO	NM	yс	ARDI	AL :	INFA	RC7	TION			
09	ate be e hysician the buri	dical		L	SEVE	RE PE	RIPHER	AL	/AS	CULAR	DI	SEASO	E				
Box 68760	Hospital or Attending Physician: The law requires that the death certificate be executed thous after death. Furneral Director: After this certificate has been signed by the attending physician and tely filled in by the funeral director, page 2 should be detached for use as the burial-transit		IF FEMALE: 23b. Was decedent pregnar in the past 12 months? 1 Yes 2 No	at 2	3c. If yes, outco 1 Live B 4 Pregna 9 Unkno	ant at time of o		Ectopic p		у					ate of delive	ery Day	Year
P.O.	es that the dea signed by the a i be detached f	Phy	9 Unknown Part II. Other significant co	nditions co			sulting in the u	nderlying c	ause giv	en in Part I.		23e Did t	tohacco	LISE CONT	ribute to th	0 001180	of doath?
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Division of Vital Records,	I or Attending Ph after death. Director: After thi d in by the funeral	Certificate:		Could not be etermined		f Injury - At ho , etc. (Specify	ome, farm, stre	et, factory,	office		28	f. Location (S City or Tov			er or Rural	Route Nu	ımber,
	To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b	Medical	29a. Certifier 1 Cert	ifying Physi	cian: To the bes	st of my knowl	ledge, death o	ccurred at t	he time,	date and pl	ace, and	due to the ca	ause(s)	and manr	ner as state	ed.	
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	To with		29b. Signature and title of co		HOSPIT	AL151			License D O	number 07191	2				25,		
5			30. Name and address of pe	SHEE	mpleted cause ELA 90	of death (Item	23a) (Type, Pr	int) SQC	IAR	E DRI	VE :	BALTII	mar	E, M	D. 2	1/23	37
	Stat Registra	e	31. Date filed (Month, Day, You No. 1)	ear) 2012	32. Reg	gistrar's Signat	barke	,					_				
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DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			_ State	faryland / Depa			ental Hygie	ene	
	_		Registrar 1. Decedent's Name (First, Middle, Last)	Cer	tificate of Dea		Reg 2. Date of Death	No. 2	091,99
	Physicia		Patrick Sokas	3			Month March	Day Year 201	3. Time of Death 2 1648 M
N.	Medic Examin		4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Loc	cation of Death	March	4c. County of Dea	th
J.			31 Lambourne Drive		Towsor	1		Baltim	ore
	Funeral Director		5. Social Security Number 213-72-2995 Usual Residence of Decedent	ge (In yrs. last birthday) 55 Yrs.		Under 24 Hrs. ours Min.	B. Date of Birth (Month, Day, Ye June 28	ear) Co	thplace (State or Foreign untry) Maryland
	land show dat	tor	10a. State 10b. County	10c. City, Town or Lo					10d. Inside City Limits
	Mary 28a-f otifie	irec	Md. Baltimore	Towson					1 🗆 Yes 2 🗗 No
	n with the is 23a or nust be n	Funeral Director	10e. Street and Number 31 Lambourne Drive		10f. Zip Code 21204			United St	
21215-0036	e flied within 72 hours after death with the Maryland tal Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Completed by Fu	11. Marital Status 1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced 12. Was Decedent Armed Forces 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates.	X _{No}	Was Decedent of Hispar f Yes, specify Cuban, M I ☐ Yes 2 ♠No S/	lexican, Puerto Ri	fy Yes or No- can, etc.)	14. Race - Ame Black, Whit Specify: Whi	e, etc.
15-(72 hou matu edica	plet	15. Decedent's Education (Specify only highest grade completed)	(Give i	dent's Usual Occupation kind of work done during	n g most of working	16	b. Kind of Business.	/Industry
212	led within 7 Hygiene. other than ent, the M	Con	Elementary/Secondary (0-12) College (1-4 or 5+	5+) life. Do	O NOT use retired) ychiatrist			Medical	
pu	filed val Hyg	Be o	17. Father's Name (First, Middle, Last)	-	18.	. Mother's Name (First, Middle, Maid	den Surname)	
yla	ould be fill d Mental marked o matic eve	입	Peter Paul Sokas			Jeann	e O'Tool	e 	
Maryland	sho han 7 is trau		19a. Informant's Name/Relationship (Type, Print)		ng Address (Street and I . Woodbine 1				Code)
	1 and 2 soft Health item 27 other tra		Regina Sokas/Sister 20a. Method of Disposition	20b. Place of Dispo	sition (Name of	Da Da		c. Location - City or	Town, State
Baltimore,	nit. Page 1. partment of 1 portant: If its injury or of injury or of ie.		1 ☐ Burial 2 ☐xCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	e Ardent C	rematory or other place)	3-26-	2012	Hanover, M	ld.
Balt	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Licensee		. Name and Address of				ly F.H.Inc.
			23a. Part 1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each lir	ed the death. Do not ente					Approximate Interval Between
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387	certifical anding ph use as th	/Me	IF FEMALE:						
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P.0	that the	by Pi	Part II. Other significant conditions contributing to death	but not resulting in the u	nderlying cause given ir	n Part I.	23e. Did tobac	co use contribute to	the cause of death?
ds,	equires en siç rould b	ted	Obesity, Hypertension				1 🗆 Yes	2 ∑X No 3 □ P	robably 4 🗌 Unknown
Division of Vital Records, P.O.	The law ate has page 2	Completed					24a. Was en autopsy performed	prior to death?	topsy findings available completion of cause of
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τVi	Physi this o ral dir	<u>1</u>	1 No 1 Inpat 27. Manner of Death 28a. Date of inj	tient 2 ER/Outpatien				e 6 Other (Spec	ify)
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			> Sonal Syl M	1)	D6878	37		March 26	, 2012
	12		30. Name and address of person who completed cause of a Sonal Singh 624 N. Broad			Md. 2120)5		
	Stat		31. Date filed (Month, Day, Year) MAR 2 7 2012	dway 680B rar's Signature	. N. I				
	Registra	ar	MAR 2 1 2012 Chow	w p. ga	vee				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene = State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 01:00 AM 2012 ranc Medical Name (if not institution, give street and number, 4c. County of Death 4a. Facility 4b. City. Town, or Location of Death **Examiner** tomore 8. Date of Birth (Month, Day, Year) March 5,1936 (In vrs. last birthday) Birthplace (State or Foreign Country) Social Security Number If Under 24 Hrs. **Funeral** Hours 212-32-8862 Director 1 🔀 M 2 🗆 F 76 Maryland d Mental Hygiene. marked other than "natural", or items 23a or 28a-f show matic event, the Medical Examiner must be notified at 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Md. N/A Baltimore 1X Yes 2 No 10e, Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 6632 Hartwait Street 21224 USA Page 1 and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black White etc 1 Never Married 2 Married 1 X Yes 2 No If Yes, Give þ Maryland 21215-0036 Specify: White 1 ☐ Yes 2 No Specify. 3 Widowed 4 X Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Bartender Restaurant 10 years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Henry Siemek Margaret Davis other traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) f Health a item 27 i 907 Bernadette Drive, Forest Hill, Md. 21050 Cathy Budnichuk Daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of H Important: If ite any injury or oth March 27. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Dundalk, Maryland St. Stanislaus Cem. 2012 4 Donation 5 Other (Specify) 22. Name and Address of Facility

Connelly Funeral Home of Dundalk, P.A. Signature of Funeral Service Licensee 7110 Sollers Point Road, Dundalk, complications that caused the eath. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease Approximate nly one cause on each line shock, or heart failure. List Interval Between Onset and Death Immediate Cause (Final Physician/ Injun Spine disease or condition resulting in death) ervical Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying EX ! MINE Examine Due to (or as a consequence of) OF BLIFFER ION PARAMED BY WEDICH Cause (Disease or injury and use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) attending physician I for use as the buria Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Other (specify) Pregnant at time of death signed by the a' 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed peen s 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy has page 2 death? hours after death. Ineral Director: After this certificate I 2 No Hospital or Attending Physician: filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be 1 Yes Other: မ 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred ₁ ☐ Natural injury 5 Pending work? 1 🔲 Yes 2 XNo Accident Investigation fram 9-2012 10:00 A 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4300 Block a within 24 hours a To the Funeral I Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 24 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar Eleni Benson

MAR 2

31. Date filed (Month, Day, Year)

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Street Boltimore ManyLand 21287